

University of Richmond
Flexible Spending Account Plan
Summary Plan Description

Effective as Amended and Restated January 1, 2020

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30INTRODUCTION

University of Richmond has implemented a Section 125 Cafeteria Plan and a Flexible Spending Account Plan to enable you to purchase certain benefits on a pre-tax basis. The Flexible Spending Account Plan consists of two reimbursement accounts that are further described below.

If there is any difference between information described in this Summary Plan Description and the Plan's formal documentation, the formal documentation will control. The formal documentation is subject to rules, regulations, and interpretations under Section 125 of the Internal Revenue Code and other provisions of the Internal Revenue Code.

FLEXIBLE SPENDING ACCOUNTS

As benefit options under the University of Richmond Section 125 Cafeteria Plan, the University of Richmond Flexible Spending Account Plan enables you to use pre-tax dollars to pay for many medical and dependent care expenses. There are two separate reimbursement accounts available to you:

- Medical Reimbursement Account for qualifying medical, dental and vision expenses incurred by you and your eligible dependents; and
- Dependent Care Account for the costs of day care for your children or other eligible dependents.

Special rules apply to the types of expenses eligible for reimbursement under each account. This booklet provides guidelines for using these accounts and lists some of the eligible expenses. If you have questions about flexible spending accounts, contact University of Richmond.

ELIGIBILITY

Each Employee who normally performs services for the Employer of at least 30 hours per week may elect to participate in the Plan as of the beginning of the next following Coverage Period. Any Employee whose employment begins after the beginning of a Coverage Period may begin participation on the First day after the end of waiting period after completing 1 months of service with the Employer.

Annual Enrollment Period

An annual enrollment period will be scheduled by the Company prior to the beginning of each plan year. At that time you will receive enrollment materials describing the Flexible Spending Accounts and the other options available to you under the Plan.

If you decide to participate in one or both of the Flexible Spending Accounts, you must elect the total amount of your annual compensation you wish to deposit into each account during the next plan year. The amount you elect to deposit into the appropriate Flexible Spending Account will be deducted prorata from your pay beginning the first payday of the plan year. After an election

is made, it may not be modified until the next annual enrollment period unless there is a Change in Status or other IRS authorized event that allows an election change.

Change in Status Events

Rules of the Internal Revenue Code require that generally, you may not change the amount you are depositing to your Flexible Spending Account Plan until the next annual enrollment period. However, you will be allowed to make a change if the change is a *Change in Status Event* and the *Consistency Rule* is satisfied. Valid *Change in Status Events* include the following:

For both Medical Reimbursement and Dependent Care Accounts:

Change in Employee's Legal Marital Status (marriage, divorce, annulment, legal separation or death of spouse).

Change in Number of Dependents (events that change an employee's number of dependents, such as birth, adoption, placement for adoption or death).

Change in Employment Status of Employee, Spouse or Dependent (any of the following that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite, or a change from an eligible to an ineligible employment status or classification).

Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements (events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, student status, or similar circumstances). Please note that, effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

Other *Change in Status Events* may be allowed if they are acceptable under interpretations of the Internal Revenue Code. If you have questions, please ask your Employer's benefits representative.

If you experience a *Change in Status Event* and desire to make a change, you must make the change no later than 30 days following the *Event*.

Consistency Rule

A change must be "on account of and correspond with" a *Change in Status Event*. To meet this requirement, the change that you wish to make must be on account of and correspond with a *Change in Status Event* that affects eligibility for coverage under an employer's plan. This rule is satisfied as to the Dependent Care Account if the *Change in Status Event* affects expenses under that Account, such as when the child becomes 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent with" a *Change in Status Event* will be made by the Plan Administrator (in its sole discretion) in

accordance with interpretations of the Internal Revenue Service. If you have questions, please ask your Employer's benefits representative.

Other Events That May Allow Election Changes

Cost Changes. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If the caregiver is a relative, no change is permitted.

Significant Coverage Change/Curtailment. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. It may apply, for example, when there is a change in provider, or eligibility for state-funded school resulting in decreased need for child care expenses.

Change in Coverage of Spouse or Dependent Under Other Employer's Plan. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If there is a change in your, your spouse's, or your dependent's coverage under another employer's plan, you may be allowed to change your election under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

- **Judgment, Decree, or Order.** If a judgment, decree, or order (collectively called "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act) requires an employee to cover a child under the Medical Reimbursement Account, the employee may increase deposits to cover the child. Likewise, if the order requires another individual to provide coverage for the child and coverage is, in fact, provided, then the employee may reduce deposits.
- **Medicare and Medicaid.** If an employee, spouse, or dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change to reduce deposits to the Medical Reimbursement Account to take into account Medicare or Medicaid. Likewise, if the employee, spouse, or dependent loses eligibility for coverage under Medicare or Medicaid, the employee may increase deposits to the Medical Reimbursement Account to take into account loss of that coverage.

Additionally, the Plan's Administrator may modify your election(s) downward during the plan year if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

HOW THE SPENDING ACCOUNTS WORK

You can use your Flexible Spending Accounts to pay for a variety of expenses related to medical care and dependent day care. You may participate in one account or both accounts, or you may decide not to participate at all.

The following describes the procedure:

- During the annual enrollment period you indicate the total amount you wish to deposit in each account during the coming year.
- The annual amount you elect will be divided evenly over the appropriate number of pay periods. Each pay period, an equal portion of the total amount will be deducted from your compensation and credited to the appropriate account(s).
- When you incur eligible expenses, you submit a reimbursement account claim form together with the original itemized bill or receipt or the explanation of benefits (EOB) form from your insurance carrier.
- In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected to deposit into your Medical Reimbursement Account.
- Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Account at the time you submit your request. If your claim exceeds the amount currently available in your Dependent Care Account, you receive additional reimbursements as more money is deposited into your account through payroll deductions.

TAX ADVANTAGES

The cash compensation (wages) you receive from University of Richmond is taxable. However, when you allocate a portion of your compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

You do not have to pay taxes on the money you receive as reimbursement of eligible medical or dependent care expenses from your Flexible Spending Account Plan.

Social Security/Other Benefits May Be Affected

Since you do not pay Social Security taxes on any compensation you deposit to your Medical Reimbursement Account or your Dependent Care Account, your future Social Security benefit could be slightly reduced. Although this reduction usually is quite small, it could occur if your compensation falls below the annual Social Security taxable wage base as revised each year. The resulting decrease in your taxable compensation could impact other benefits which may be available through your employer.

MEDICAL REIMBURSEMENT ACCOUNT

You can deposit between \$'100.00 and \$'2,750.00 of your compensation into your Medical Reimbursement Account each year. You can use the money in your account to reimburse yourself for any eligible medical expense for yourself or your dependents which has not been paid by any other benefit plan. For purposes of the Medical Reimbursement Account, eligible dependents include your spouse, your dependent children, and any other person who is your dependent for federal tax purposes (i.e., any person for whom you claim an exemption on your tax return). Please note that effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

Eligible Medical Expenses

Eligible medical expenses include most expenses that qualify as medical expenses under the Internal Revenue Code. A partial listing of eligible expenses includes the following; items marked with an asterisk (*) may require additional documentation or reimbursement may be limited to the difference between a normal item and a special need item:

Deductibles & Co-Payments

Dental Expenses:

Routine & Preventive Services

X-Rays

Orthodontia & Appliances

Restorative & Major services including fillings, crowns, implants, bridges

Dentures

Periodontal Services

Vision Care Expenses:

Exam (Optometrist or Ophthalmologist)

Rx Glasses & Contact Lenses & Supplies

Corrective Surgery (RK & Lasik)

Prescription Drugs including prescription vitamins and birth control pills

Medical Equipment:

Wheelchairs or Lifts

Crutches

Oxygen Equipment & Supplies

*Air Purifier/Filters**

*Special Beds or Mattresses**

Blood Pressure Monitor

Glucose Monitor

Diabetic Supplies including test strips and Insulin

Hearing Expenses including testing and hearing aids plus batteries and repairs

Counseling & Psychiatric Treatment:

Psychiatrists & Psychotherapists

Psychologists

Legal fees related to commitment of mentally ill person

Excluded: marriage/family counseling

Therapy:

Treatment for Alcoholism or Drug/Chemical Dependency

Physical Therapy

Speech Therapy

Prescription Smoking Cessation

Prescription Weight Loss program

Physical Examinations:

School & Work Physicals

Annual Physical Exam including pap smears, mammograms and prostate screening

Assistance for Disabled Persons:

*Braille or other special books/items or cost of specially equipping home or car for access by disabled person**

Guide animals (purchase & care)

Special Alert Systems

Fees & Services:

Physicians, Surgeons, Anesthesiologists, OB/Gyn, or other specialists

Ambulance (Air & Ground)

Nursing (including room & board)

Fertility Treatment

Sterilization & Reversals

Legal Abortion

Medically necessary cosmetic services (e.g., following accident or mastectomy, etc.)

Chiropractic services

Alternative/Holistic Services: medically necessary treatment by licensed or certified practitioners including acupuncture and massage therapy

Other:

Medical Records

Travel necessary to seek medical treatment (limitations apply)

Organ/Tissue Donation Expenses

*Special Diet**

Support Garments & Wigs*

Orthotics

Prosthesis, Artificial Limbs

*Orthopedic shoes**

Shipping & Handling charges

Disability testing & consultations

If you use the Medical Reimbursement Account to pay for a particular medical expense, you cannot claim the same expense as a deduction on your income tax return.

Effective for all expenses incurred on and after January 1, 2011, the costs for a medicine or a drug will be eligible for reimbursement only if the medicine or drug requires a prescription, is available without a prescription (an over-the-counter medicine or drug) and you obtain a prescription, or is Insulin.

If you receive a reimbursement from your Medical Reimbursement Account and reimbursement for the same expense through your medical or dental coverage or another health care plan, you must refund the reimbursement you received from your Medical Reimbursement Account to the Plan.

Medical Expenses Not Eligible for Reimbursement

Not all medical expenses are eligible for reimbursement from your Medical Reimbursement Account. Here are some examples of expenses which are not eligible for reimbursement:

- Cosmetic Expenditures (e.g., teeth whitening, dermabrasion, chemical peels or spider vein treatment)
- General Wellness expenses (e.g., health club dues, special foods and supplements, vitamins, exercise programs and equipment, or weight loss programs)
- Insurance Premiums (e.g., replacement insurance for contact lenses or other health plan policies)
- Other: Missed Appointment, Late Payment or Interest Charges

Submitting a Claim

You can submit a claim for an eligible medical expense at any time during the Plan Year. Obtain a Request For Medical Reimbursement form from the claims administrator or your benefits representative and attach a copy of the original itemized bill or receipt for an expense not covered under your medical, dental, or vision coverage, or the explanation of benefits from the insurance carrier. Reimbursements will be made at least monthly.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. You incur an expense when the service is provided, and not when the bill is sent or payment is made. For example, as a general rule, if the Plan Year is the calendar year, and you had a physical exam in 2012 and paid for it in 2013, you cannot submit a claim for the cost to your 2013 Medical Reimbursement Account. You can continue to submit claims for eligible medical expenses incurred during the Plan Year until March 31 following the end of the Plan Year.

Notwithstanding the foregoing, note that your employer may adopt a grace period for Medical Reimbursement Accounts available under the Plan. If the employer adopts a grace period, then you may be able to be reimbursed for eligible medical expenses incurred and paid for during the first two months and fifteen days following the applicable Plan Year. For example, if your employer has adopted a grace period, then you may be eligible to be reimbursed with funds you set aside in 2013 for medical expenses you incur up to March 15, 2014.

Alternatively, effective January 1, 2014, you may be eligible to carry over to the next Plan Year up to \$500.00 remaining in your account as of the deadline for submitting claims. This carryover option is available *only* if your Plan does *not* have the grace period option discussed above. The funds carried over may be used to pay for eligible medical expenses incurred in the subsequent Plan Year only. If available, reimbursements will be made first from unused amounts credited for the current Plan Year, and, only after exhausting those current Plan Year amounts, then reimbursed from unused amounts carried over from the preceding Plan Year.

Your employer should discuss the availability of these options in its open enrollment materials. Please contact your employer's benefits representative to determine whether the Plan has a grace period or allows for carryovers.

Unused Balances

As a general rule, unless the carryover or grace period options apply, if you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 31 deadline, you will forfeit your unused balance unless you are eligible for the carryover option discussed above.

All forfeitures from Plan participants will be used by the employer to offset any losses it has incurred for benefit payments under the Medical Reimbursement Account Plan and/or to reduce costs of administering the Plan. After this, forfeitures may be used in any manner authorized by relevant law.

Note that your unused balance may be affected by either a grace period or a carryover option offered by your Employer. Please contact your Employer's benefits representative if you have further questions about what happens to your unused balance at the end of a Plan Year.

Qualified Reservist Distributors

Effective June 17, 2008, you may request a Qualified Reservist Distribution of any unused balance in your Medical Reimbursement Account.

A Qualified Reservist Distribution is a distribution of all or a portion of your Medical Reimbursement Account if:

You were ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and

The distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year you receive your order or call.

Qualified HSA Distributors

In certain circumstances you may be allowed a Qualified HSA Distribution.

A Qualified HSA Distribution is a one-time option that allows, in limited circumstances, you to request that your unused Medical Reimbursement Account be transferred to a Health Savings Account (HSA). You should review Section 5.04 of the Plan for further details. As required by Federal tax law, Qualified HSA Distributions are not allowed after December 31, 2011.

DEPENDENT CARE ACCOUNT

You can deposit between \$'100.00 and \$'5,000.00 of your compensation into your Dependent Care Account each year. (If you are married, and your spouse files a separate tax return, you can deposit only up to \$2,500.) You can use the money in your account to reimburse yourself for dependent care costs which you incur so that you and your spouse (if any) can work. If you are married but your spouse does not work, he or she may be considered working during any month that he or she is a full-time student or is incapable of caring for himself or herself.

Special Rule

There are additional limits on the amount you can deposit to this account. The amount of your deposit cannot be greater than your income or your spouse's, whichever is lower. For example, if you earn \$15,000 a year and your spouse earns \$4,500, the maximum you can deposit for dependent care expenses is \$4,500.

Under this special rule, if your spouse is a full-time student or is incapable of caring for himself or herself, he or she is assumed to have a monthly income of \$250 if you have one eligible dependent, or \$500 if you have two or more eligible dependents.

Eligible Dependent Care Expenses

You can use your Dependent Care Account to pay for dependent care expenses for qualifying individuals. A qualifying individual is:

- a child under age 13 whom you are entitled to claim as a dependent on your federal tax return; and/or
- a spouse or other dependent (e.g., your parent or your spouse's parent) who is physically or mentally incapable of self care, who has the same principal place of abode as the Participant for more than half of the taxable year, and who spends at least eight hours a day in your home. [Note that unless a technical correction is made to the Internal Revenue Code, effective as of January 1, 2005, such dependent must also have gross income that is less than the exemption amount (\$3,900 in 2013).]

Eligible dependent care expenses may include expenses for:

- care at dependent care centers that meet all applicable state and local requirements and provide care for more than six individuals;

- day camps (not overnight camps);
- services from individuals (other than you or your spouse's dependent or child less than age 19) who provide care inside or outside your home;
- services of a housekeeper, maid, cook or similar employee, for that portion of the time which is related to the care of a qualified individual.

The caregiver may be a relative if he or she is at least 19 years old and is not someone you can claim as a dependent on your federal tax return. Expenses or fees related to education cannot be reimbursed. Other expenses not listed above that are authorized by the Internal Revenue Code may be reimbursed.

Tax Credit Versus Dependent Care Account

The federal government allows you to take a tax credit on your federal income tax return for qualified dependent care expenses. The difference between the Dependent Care Account and the tax credit is that the Dependent Care Account provides a reduction of your taxable income, while the tax credit offers a direct reduction of the amount of tax you pay.

Your individual financial circumstances will determine which method is best for you. You might wish to consult with a tax consultant or financial advisor before making a decision.

Submitting a Claim

You can submit a claim for an eligible dependent care expense at any time during the Plan Year. Obtain a No Wait Dependent Care Reimbursement form from the claims administrator or your benefits representative and attach the original itemized bill or receipt from the provider of services, showing the provider's Social Security number (or tax identification number), the dates of service and the amount. Reimbursement for eligible expenses will be processed within 24 hours after receipt of the claim.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. You can continue to submit claims for eligible dependent care expenses incurred during the Plan Year until March 31 following the end of the Plan Year.

Notwithstanding the foregoing, please note that your employer may adopt a grace period for Dependent Care Accounts available under the Plan. If the employer adopts a grace period, then you may be able to be reimbursed for dependent care expenses incurred and paid for during the two months and fifteen days following the applicable Plan Year. For example, if your employer has adopted a grace period, then you may be eligible to be reimbursed with funds you set aside in 2012 for dependent care you incur up to March 15, 2013. Please contact your Employer's benefits representative to determine whether the Plan has a grace period for Dependent Care Accounts.

Unused Balances

If you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 31 deadline, you will forfeit your unused balance.

All forfeitures from Plan participants will be used by the employer to reduce costs of administering the Plan or may be used in any manner authorized by relevant law.

CHANGES TO EMPLOYEE'S STATUS

If your employment status changes, participation in each of the reimbursement accounts may be affected. The effects of certain changes are described below.

Medical Reimbursement Account

Your participation in the Medical Reimbursement Account would be affected as follows, based on the type of employment change involved.

- **Leave of absence under the FMLA.** Your deposits may continue for as long as you are on paid leave or, if the leave is unpaid, you may elect to continue under the Account and make deposits in a manner approved by your employer. You should discuss payment methods with your employer if you are on unpaid leave. If you wish, you can elect to cease making deposits while you are on FMLA leave. If you cease making deposits, you will not be considered a participant in the plan, and you will not receive reimbursement for expenses incurred during the time you were not a participant. When you return from FMLA leave, you can be reinstated in your account. If any generally applicable changes were made to the plan while you were out, those changes will also apply to you.

Upon return from an FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a medical reimbursement spending account, provided that Employees on a non-FMLA leave are also required to be reinstated into the spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave. For example, if an Employee has elected \$1,200 of annual coverage under a medical reimbursement account (\$100 pre-tax funding monthly) and is on an FMLA leave during April, May, and June, during which coverage ceases, Employee on return from the leave in July may resume coverage at \$1,200 by paying \$150 per month from July through December. Alternatively, the Employee may resume coverage at the reduced level of \$900 annually by paying \$100 per month from July through December.

- **Non-FMLA Leave of Absence.** If your employer's policies provide for a paid leave of

absence that is not covered by the FMLA, your deposits continue as long as your salary continues. If your leave of absence is unpaid, you may have a permissible *Change in Status Event* that would allow you to discontinue your deposits and cease participation. Please refer to the section on “*Change in Status Events*.” If you want to continue deposits even though you have had a *Change in Status*, those deposits would be made with after tax income. Upon return from a non-FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a medical reimbursement spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave.

- **Death.** In the event of your death, your deposits stop. However, your surviving dependents may submit for reimbursement, eligible expenses incurred prior to your death. Claims for eligible expenses incurred prior to your death must be submitted by March 31 following the close of the Plan Year.
- **Change to ineligible employment status.** Your deposits stop. However, you can continue to request reimbursement of eligible expenses incurred through the date of the employment status change. Claims must be submitted by March 31 following the close of the Plan Year.
- **Termination of employment.** Your deposits stop with the last paycheck you receive after termination. However, you may continue to request reimbursement of eligible expenses incurred through your termination date. Claims must be submitted by March 31 following the close of the Plan Year.

If the events described above cause a loss of coverage under the Medical Reimbursement Account, you may have experienced a “qualifying event” under COBRA. COBRA is generally applicable to employers who employ 20 or more employees. If COBRA applies and you lose coverage due to a qualifying event, then those who were covered under the Medical Reimbursement Account before the qualifying event may be able to continue participation in the Medical Reimbursement Account by timely electing and paying for COBRA coverage. In addition to the premium deposits, which will generally be made on an after-tax basis for COBRA coverage, a 2% administrative fee may be charged. See Exhibit A at the end of this Summary Plan Description for more information about COBRA. COBRA is not available if you have a negative account balance as of the qualifying event.

Dependent Care Account

A change in employment status would affect your participation in the Dependent Care Account generally the same way as listed above for the Medical Reimbursement Account with the following two exceptions:

COBRA: Dependent Care Accounts are not considered health plans; therefore, federal COBRA

regulations do not apply. Coverage or service dates may not be extended beyond your date of termination or date of death.

Leave of Absence: If you take any leave of absence, you can cease your deposits only if the leave of absence also qualifies as a *Change in Status Event*. A leave of absence qualifies as a *Change in Status Event* only if it is unpaid. Please remember that an eligible dependent care expense is one that allows you and your spouse to work. If you or your spouse are not working, dependent care expenses incurred during that time may not be expenses that are properly reimbursable. For this reason, you may want to consider timely ceasing deposits if you take an unpaid leave of absence. If you choose to continue deposits, those deposits would be made on an after-tax basis.

MORE IMPORTANT FACTS ABOUT THE REIMBURSEMENT ACCOUNTS

The Plan is provided through and administered by your Company. Claims are administered by Flores & Associates, LLC, P.O. Box 31397, Charlotte, NC 28231-1397 (the “Claims Administrator.”)

Plan Names

The University of Richmond Section 125 Cafeteria Plan and Flexible Spending Account Plan. The Flexible Spending Account Plan contains two component accounts: Medical Reimbursement Accounts and Dependent Care Accounts.

Plan Documents

University of Richmond’ Plans are fully described in the Plans’ legal documents. There is another booklet available to you that describes the Section 125 Cafeteria Plan. This booklet describes the major provisions of the Flexible Spending Account Plan in easy to understand terms. It is shorter and far less technical than the Plans’ legal documents. If there is any conflict or inconsistency between this booklet and the Plans’ legal documents, or if this booklet does not cover or only partially covers any provision in the legal documents, the Plans’ legal documents govern. If you have any questions about the Plans or if you would like to examine the Plans’ legal documents, contact University of Richmond. It is intended that the Plans will be administered in accordance with all relevant statutory and governmental authority. To the extent that any Plan provision is contrary to any statutory and governmental authority, such authority will govern operation of the Plans.

Effective Date

The effective date of each of the Plans is January 1, 1989.

Plan Sponsor/Plan Administrator

University of Richmond

28 Westhampton Way
Univ of Richmond, VA 23173
804.289.8167

The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the plan. The Plan Administrator has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the Plan. The Plan Administrator may assign its duties to others. The function of claims administration, in accordance with the terms of the Plan documentation, has been assigned to the Claims Administrator.

Claims Administrator

Flores & Associates, LLC
P.O. Box 31397
Charlotte, NC 28231-1397
(704) 335-8211

Legal Service

The agent for service of legal process for the University of Richmond Flexible Spending Account Plan is:

Shannon Sinclair, General Coun
University of Richmond
Off of the Pres., Maryland Hall
Univ of Richmond, VA 23173

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

Plan Number

501

Plan Sponsor's Identification Number

54-0505965

Plan Year

The Plan year begins on January 1 and ends on December 31.

Type of Plan

The Medical Reimbursement Account is a type of welfare plan under ERISA that reimburses

eligible medical expenses that are not reimbursed from other sources. The Dependent Care Account is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Section 125 Cafeteria Plan is authorized by Section 125 of the Internal Revenue Code and allows payment for certain benefits on a pre-tax basis.

Sources of Contributions

Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits. A minimum contribution may be required.

Benefit Payments

Benefits are paid from the employer's general assets. There is no independent source of funds or any insurance contract that guarantees the payment of benefits. For administrative convenience, the Claims Administrator processes all claims for reimbursements on behalf of the employer.

Qualified Medical Child Support Orders

If required by any Qualified Medical Child Support Order ("QMCSO") defined in ERISA Section 609(a), the Plan will extend benefit to a Participant's non-custodial child. Participants and beneficiaries can obtain from the Plan Administrator, without charge, a copy of procedures used for determining whether an order satisfies the requirements of ERISA.

Future of the Plans

University of Richmond intends to continue the Plan indefinitely. However, it reserves the right to change or to terminate the Plan, or to eliminate any benefit under the Plan, at any time without the consent of any participant or dependent. University of Richmond or any authorized officer or representative of University of Richmond can make changes to or terminate the Plan. You will be notified if any changes are made.

CLAIMS DECISIONS AND APPEALING A DENIED CLAIM

The following information is provided regarding claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act (“ERISA”). It is based upon regulations issued by the U.S. Department of Labor. Only the Medical Reimbursement Account under this Plan is a benefit that is covered by ERISA.

Claims Decisions. Within 30 days after receipt of a claim, the Plan will make reimbursement for expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied. The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process. In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial within 180 days after receipt of written notice

of the denial. Your written request should be sent to the Claims Administrator, which will forward your request for review to the Plan Administrator. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court as described under “Statement of ERISA Rights” below. In pursuing an appeal, the claimant or the duly authorized representative:

- a. must request in writing for a review of the denial;
- b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and
- c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including

your right to file a lawsuit, as described in the “Statement of ERISA Rights” below.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding. The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

STATEMENT OF ERISA RIGHTS

If you are a Participant in the Medical Reimbursement Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of any latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

COBRA Continuation Coverage

If your Employer is subject to COBRA, you may have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review Appendix A of this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from a plan covered by ERISA or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without

charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or any latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the Plan Administrator to provide the materials and to 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the Plan's money (if the Plan is considered to have money), or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns' and Mothers' Health Protection Act 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).

APPENDIX A—COBRA CONTINUATION OF COVERAGE

This Appendix A Applies Only if the Employer is Subject to COBRA

Introduction

Important information about rights you may have to COBRA continuation coverage are described below, including when COBRA coverage may be available to you and what you need to do to protect the right to receive it. As a general rule, COBRA applies to employers that normally employed 20 or more employees during the preceding calendar year.

COBRA coverage is a temporary continuation of group health coverage that is available to covered employees, spouses, and dependent children under certain circumstances when their group health coverage would otherwise end. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.

This Plan will offer COBRA coverage if the employer is subject to COBRA, and the coverage that is offered will be the coverage required by law. Nothing in this explanation is intended to change the requirements of law.

Since Medical Reimbursement Accounts qualify in some regards as group health plans, qualified beneficiaries have the right to elect COBRA only in the event the Medical Reimbursement Account is “underspent.” For an account to be underspent as of the date of the qualifying event, the qualified beneficiary must be able to receive a maximum benefit amount which is greater than the total amount of the COBRA contribution (example: an employee elects \$1200 for the plan year and on 11/1 he terminates employment. He has contributed \$1000 by the date of his termination but has submitted no claims. His COBRA payment through the end of the plan year would be \$204 ($\$1200 - \$1000 = \$200 + 2\%$ for COBRA administration costs). This account is underspent since the employee could receive a maximum benefit of \$1200 for a COBRA contribution of \$204. In determining the maximum amount of the benefit that a qualified beneficiary could receive during the remainder of the plan year, the Plan may deduct any reimbursable claims submitted before the date of the qualifying event.

COBRA will be offered only to those who have “underspent” their Medical Reimbursement Account.

What is COBRA coverage?

COBRA coverage is a continuation of group health plan coverage when that coverage would otherwise end because of certain events called “qualifying events.” Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person losing group health plan coverage who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the group health plan is lost because of the qualifying event. Certain newborns and newly adopted children may also be qualified beneficiaries. This is discussed in more detail below under the heading called “Other Individuals Who May be Qualified Beneficiaries.” The word “you” below generally

refers to each person covered by the group health plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the group health plan provides to other participants and beneficiaries who are not receiving COBRA coverage. If the coverage for others changes, it will change in the same way for those who have elected COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights and responsibilities, and will be subject to the same terms and conditions for coverage, as others who are covered by the group health plan but who have not elected COBRA (including any annual enrollment and special enrollment rights), except that those who elect COBRA must pay for the entire cost of COBRA coverage, plus an administrative fee.

The COBRA coverage under the Medical Reimbursement Account will consist of the coverage amount in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to 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.

Qualifying Events

If you are an employee, you will be entitled to elect COBRA if your account is underspent and you lose group health coverage under the terms of the Plan because of one of the following qualifying events:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will be entitled to elect COBRA if the account is underspent and you lose group health coverage under the terms of the Plan because of any of the following qualifying events:

- (1) Your spouse dies; or
- (2) Your spouse's hours of employment are reduced; or
- (3) Your spouse's employment ends for any reason (other than for gross misconduct);
or
- (4) You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
- (5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will be entitled to elect COBRA if the account is underspent and you lose group health coverage under the Plan because of any of the following qualifying events:

- (1) Your parent-employee dies; or
- (2) Your parent-employee's hours of employment are reduced; or
- (3) Your parent-employee's employment ends for any reason (other than for gross misconduct); or
- (4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- (5) Your parents become divorced or legally separated; or
- (6) You no longer meet the group health plan's definition of a dependent child and are therefore no longer eligible.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been properly notified that a qualifying event has occurred. However, COBRA will only be made available to those who have "underspent" their accounts. When the qualifying event is the end of employment (other than for gross misconduct), the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. You need not provide notice of these particular events. However, you must give notice of other qualifying events, as explained below.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the qualifying event. Notice can be given by the employee, by a qualified beneficiary, or by their representative.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to elect COBRA.

After your notice has been received, you may be asked to provide additional information. For example, you may need to provide a copy of a divorce decree, a birth certificate, or a school transcript.

Electing COBRA Coverage

Once University of Richmond receives notice and satisfactory proof that a qualifying event has occurred, and determines that your account is “underspent,” COBRA coverage will be offered to each qualified beneficiary who loses group health coverage because of the qualifying event. You will receive information about electing COBRA, and you should follow the instructions given.

Independent Election Rights

Each qualified beneficiary will have a separate and independent right to elect COBRA coverage under the group health plan that covered him or her on the day before the qualifying event. For example, if both the employee and spouse have the right to elect COBRA coverage, the employee can elect COBRA even if the spouse does not. If several dependent children have the right to elect COBRA, COBRA can be elected for only one, for some, or for all of the dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries. Also, a parent or legal guardian may elect COBRA on behalf of their minor dependent children.

60-Day Election Period

To elect COBRA, you must complete the election form that will be provided to you and timely return it as instructed. Under federal law, you have 60 days to elect COBRA. The 60-day period is measured from the later of the date coverage is lost under the terms of the Plan or the date of the COBRA election notice. If you want to elect COBRA, the election form must be properly completed, placed in an appropriate envelope with correct postage and correct address, and postmarked within the 60-day election period. If mailed, your election is considered to have been made on the date it is postmarked. The form should be mailed to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the election form to the Plan Administrator (your employer), within the 60-day period. If hand-delivered, your election is considered to have been made on the date that it is received.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage. You do not have to send any payment with your election form. Important information about paying for COBRA coverage is included below under the heading, “Cost of COBRA Coverage.” (Information is also provided below about a special second election period for certain individuals eligible for Federal Trade Adjustment Assistance.)

If you reject COBRA coverage before the due date of the election form, you may change your mind as long as you furnish a completed election form before the end of the 60-day election period. However, if you do this, COBRA coverage will begin on the date you furnish the election form and not on the date that you lost coverage under the terms of the Plan as a result of the qualifying event.

Special Considerations in Deciding Whether to Elect COBRA Coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to

elect COBRA will affect your future rights under a federal law known as HIPAA that applies to most group health plans. First, if you have more than a 63-day gap in health coverage, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Election of COBRA may help you not have a gap in your health coverage. Second, if you do not elect and take COBRA coverage for the maximum time it is available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions. Finally, you should take into account that HIPAA provides for special enrollment rights. Under HIPAA, individuals have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after group health coverage under your employer's group health plan ends because of a COBRA qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you take COBRA coverage for the maximum time it is available to you.

How Long Does COBRA Coverage Last?

As explained above, COBRA coverage is a temporary continuation of group health coverage. The COBRA coverage periods described below are maximum coverage periods. You should keep in mind that COBRA coverage can end early, as explained later under the heading, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, COBRA coverage under the Medical Reimbursement Account offered under this Plan can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Employee's Medicare Entitlement Followed by End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before one of these qualifying events, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Medical Reimbursement Account offered under this Plan can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Employee's Death, Entitlement to Medicare, Divorce, Legal Separation, or Child's Loss of Dependent Status.

When the qualifying event is the death of the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the terms of the Medical Reimbursement Account Plan, COBRA coverage can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

The coverage periods described above are maximum coverage periods. COBRA coverage will automatically terminate before the end of the maximum coverage period if:

- (1) Any required premium is not paid in full on time;
- (2) A qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. You should provide notice if this other coverage begins, as explained below;
- (3) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA. You should provide notice if Medicare entitlement occurs, as explained below; or
- (4) The employer ceases to provide any group health plan for its employees.

In addition to the above situations that would cause the COBRA maximum coverage period to end early, COBRA coverage will also end for any reason that the plan would terminate the coverage of a participant or beneficiary who is not receiving COBRA (such as for fraud or misrepresentation).

Notices to be Provided by Qualified Beneficiary if COBRA Ends Early Due to Other Group Health Plan Coverage or Medicare Entitlement

COBRA coverage will terminate (retroactively if necessary), as of the date it should have ended as allowed by COBRA, even if you have not provided the notices requested of you above in this Termination of COBRA Coverage section. You may have to repay all benefits that were paid by the plan for expenses incurred after the date COBRA should have terminated. So that you will not be put in this position, you should notify the Plan Administrator as soon as possible if a qualified beneficiary becomes covered by another group health plan as described in (2) above, or entitled to Medicare benefits as described in (3) above. You may notify the Plan Administrator in writing or by phone at the address and phone number given at the end of this explanation. Any additional procedures required by the Plan Administrator are attached.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated group health plan participant or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. (Example: If you have elected \$20 per pay period for contribution to your Medical Reimbursement Account, you may elect to continue under COBRA by paying \$20.40 for that same coverage.) Information is also provided below about special rules for certain individuals who may be eligible for a tax credit. Refer to the heading "Health Care Tax Credit."

Paying for COBRA Coverage

First Payment for COBRA Coverage

If you elect COBRA, you do not have to make a payment when you send in your COBRA election. However, you must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. (The date you elect COBRA is the date your COBRA election form is postmarked, if mailed; otherwise, the date your election is received at the office of the Plan Administrator.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the group health plan. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator at the address shown at the end of this explanation. You may also hand-deliver a payment to the office of the Plan Administrator at the address shown at the end of this explanation. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the group health plan would have otherwise terminated, up through the time you make the first payment. You are responsible for making sure that the amount of your first payment is correct. You should contact the Plan Administrator as shown at the end of this explanation to confirm the correct amount of your first payment.

Claims for reimbursement will not be paid until you have elected COBRA and made the premium payment.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of coverage. These monthly payments are due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before its due date, your coverage will continue for that month without any break. You are responsible for making sure that your premium payments are made on time. You will not be

given notices of payments that are due. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment, but your coverage is subject to being suspended as explained below.

If you make a monthly payment after its due date but before the end of the 30-day grace period for that month, your health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim you submit for reimbursement while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.

Other Individuals Who May be Qualified Beneficiaries

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is timely enrolled in the group health plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. The child must meet all other requirements for coverage and enrollment under the plan.

Special Rules for Federal Trade Adjustment Assistance

Special COBRA rights apply to employees who lost health coverage associated with their employment being adversely affected by international trade and who qualify for Trade Adjustment Assistance or Alternative Trade Adjustment Assistance. These employees are entitled to a second opportunity to elect COBRA, if they did not elect it during the initial 60-day election period. The second election period begins on the first day of the month in which you become eligible for trade adjustment assistance (or would be eligible except for the requirement to exhaust unemployment benefits). The second COBRA election period can last for up to 60 days, but the election must also be made within the six months immediately after the date group health coverage was originally lost. If you elect COBRA coverage during the second election

period, it is effective on the first day of the second election period and not on the date coverage was originally lost. However, the maximum period of COBRA coverage is still measured from the date of the original qualifying event. The maximum period of COBRA coverage under the Medical Reimbursement Account is through the end of the plan year in which the qualifying event occurred.

Healthcare Tax Credit

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (as described in the preceding heading) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage.

If you have questions about these new tax provisions, you should call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If You Have Questions

Questions about your rights under COBRA should be addressed to the Plan Administrator whose address and telephone number are provided at the end of this explanation. Questions about your rights under the Plan should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be mailed to the Plan Administrator whose name and address are provided at the end of this information about COBRA. You should also keep for your records a copy of any notices you send about COBRA.

Plan Administrator

The name and address of the Plan Administrator is:

University of Richmond
28 Westhampton Way
Univ of Richmond, VA 23173
804.289.8167

COBRA Administrator

The name and address of the COBRA Administrator is:

University of Richmond
28 Westhampton Way
Univ of Richmond, VA 23173
804.289.8167

Continuation coverage under COBRA is at all times subject to the rules and regulations under COBRA. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

APPENDIX B – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. Governing Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). The following HIPAA definition of PHI applies to this Plan.

B. Protected Health Information

Protected health information means information that is created or received by the Plan and 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 that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

C. Provision of Protected Health Information to Plan Sponsor

- (1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- (2) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.
- (3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in subparagraph C.(5) below and obtaining written certification as further described below in Section D. below, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration

purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

- (4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).
- (5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:
 - (a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
 - (b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
 - (c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
 - (d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
 - (e) Make available PHI to comply with HIPAA’s right to access in accordance with 45 CFR § 164.524.
 - (f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
 - (g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
 - (h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA’s privacy requirements.
 - (i) 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
 - (j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the “firewall”), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement

administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, “security incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

- (6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow access to PHI only as designated by the Plan Sponsor, and only for plan administration purposes. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor’s employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

D. Certification of Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in subparagraph C.(5) above, “Conditions of Disclosure for Plan Administration Purposes.”