RIDER UNIVERSITY

PRE-TAX PREMIUM AND
FLEXIBLE SPENDING ACCOUNTS PLAN
AND
SUMMARY PLAN DESCRIPTION

AS AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2019

TABLE OF CONTENTS

Page

RIDER UNIVERSITY
PRE-TAX PREMIUM AND FLEXIBLE SPENDING ACCOUNT PLAN

AND

SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective January 1, 1999, Rider University (the "University") established the Rider University Pre-Tax Premium and Flexible Spending Accounts Plan (the "Plan"). The Plan has most recently been amended and restated effective January 1, 2019. Any claim for benefits arising prior to January 1, 2019, will be determined in accordance with the terms and conditions of the Plan in effect on the date that such claim arose.

This document serves two important functions related to the Plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), a federal law applying to employee benefit plans:

- First, ERISA requires that employers provide eligible employees with a description of the various benefit plans it maintains. Such information is to be included in a Summary Plan Description ("SPD") for each plan. This document, together with the booklets and other descriptive materials you receive from the University, constitutes the official SPD for the Plan.
- Second, ERISA requires that employee benefit plans be maintained pursuant to a written plan document. This document constitutes the written plan document under ERISA.

You and your beneficiaries may examine the Plan, all amendments, and certain other documents and records pertaining to the Plan during regular business hours or by appointment at a mutually convenient time with the Human Resources Department. You may obtain copies of the Plan and of certain reports from the Human Resources Department (a reasonable charge may be imposed for those copies, as prescribed by federal regulation). Because benefits under the Plan will be of importance to you and your family, you should retain this document as part of your permanent records. A copy may be obtained through the Human Resources Department upon request.

The Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University.

IMPORTANT: This document and the booklets and other descriptive material provided to you by the University and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University. No one speaking on behalf of the Plan or the Plan sponsor can alter the terms of the Plan. You and your beneficiaries may obtain copies of the Plan and its related documents or examine these documents by contacting the

Plan Administrator at the number and address set forth in the ADDITIONAL INFORMATION section of this document.

PURPOSE OF THE PLAN

The purpose of the Plan is to allow you to utilize a portion of your salary, on a pre-tax basis, to purchase a benefit program (or combination of benefit programs) that best meets your individual needs. The benefit programs include various medical and dental coverage options that you may elect for yourself and/or certain members of your family. The benefit programs also include flexible spending accounts ("FSAs") that you may establish to reimburse yourself for certain medical and/or dependent care expenses incurred by you and your family. The University intends that the Plan qualify as a "cafeteria plan" within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the "Code"), and that the premiums you pay for the medical or dental care coverage option you elect or your contributions to the spending account that you establish under the Plan be eligible for exclusion from your income for federal income tax purposes.

ELIGIBILITY AND PARTICIPATION

Eligible Employees

You are eligible to participate in the Plan if you are (1) an active full-time employee (i.e., not a part-time, transitory, seasonal or temporary employee) of the University who is regularly scheduled to work at least thirty (30) hours per week or (2) a full-time (as defined in the AAUP bargaining unit contract) faculty member or any other full-time member of the American Association of University Professors ("AAUP") bargaining unit. If you are eligible, you may elect coverage under any of the medical options made available to you by the University. You may also elect dental coverage and establish either or both of the FSAs available under the Plan.

Ineligible. You are ineligible to participate in the Plan if you (1) are a transitory, seasonal or temporary employee, (2) are an employee covered by a collective bargaining unit that does not specifically provide for your participation in the Plan, (3) perform services for the University pursuant to an arrangement with a leasing organization or any other third-party, including but not limited to a "leased employee" within the meaning of section 414(n) of the Code, or (4) person who is classified as an independent contractor or otherwise as a person who is not treated as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding obligation. If a person described in the preceding sentence is subsequently reclassified as, or determined to be, an employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or if the University is required to reclassify such an individual as an employee as a result of such reclassification or determination (including any reclassification by the University in settlement of any claim or action relating to such individual's employment status), such individual shall not become eligible to become a participant in the Plan by reason of such reclassification or determination.

AAUP Priority Status Adjunct Faculty. If you are a member of the AAUP Priority Status Adjunct Faculty, as determined under the terms of the Agreement Between Rider University and the Rider University Chapter of the AAUP, you may elect coverage under any of the medical options made available to you by the University. You may also elect dental coverage and establish either or both of the FSAs available under the Plan.

Eligible Dependents

For purposes of making pre-tax contributions under the medical and dental options made available by the University, your eligible dependents include your spouse (including a common-law spouse and a same-sex spouse), a domestic partner or a civil union partner and/or your children who are not more than 26 years of age. For this purpose, a child is:

- Any natural children, step children, legally adopted children or children placed with you for adoption, and

- Any foster children for whom you have legal guardianship or custody.

In addition, certain children can be covered beyond the maximum age if they are disabled. The Human Resources Department can provide you with additional information. Furthermore, the Plan will cover all dependent children, as defined above, covered by a court order requiring coverage, as described in the section entitled Qualified Medical Child Support Order ("QMCSO") below.

Expenses under the Medical Expense Account and the Dependent Care Expense Account can be submitted on behalf of your eligible dependents who meet the eligibility requirements set forth in the "Flexible Spending Accounts" section below.

Participation

If you are an eligible employee, you may elect to participate in the Plan as of the first day of the month following the date you complete a month of continuous employment, excluding the days in which the University is closed. (If you are a member of the AAUP Priority Status Adjunct Faculty, you may establish FSAs through salary reduction on the first day of the month following the date you complete a month of continuous employment, excluding the days in which the University is closed.) Thereafter, you may elect to participate in the Plan only (1) if you have a change in status, as described below under "Changing Your Election," (2) if you experience an event described below under "Special Enrollment Rights" or (3) during an open enrollment period (participation in such case will commence with the first day of the next succeeding Plan Year, January 1 through December 31).

If you fail to make an election for benefits upon your initial eligibility for coverage, you will be defaulted into single coverage under the HMO medical option and deemed to have elected no other benefits. If you fail to make an election for benefits during a subsequent open enrollment period, you will be deemed to have elected not to contribute to either of the FSAs for the upcoming Plan Year, but your prior medical and/or dental coverage, if any, will continue. Therefore, it is extremely important that you return all election materials within the time period prescribed by the University. If you decline to participate in the Plan either for yourself or any eligible dependent(s), you may be asked to state in writing that the reason for declining to participate in the Plan is because you or your eligible dependent(s) are covered under another group health plan or other health insurance.

Please note that some medical or dental coverages require you to be actively at work in order for coverage to begin. Please refer to the separate descriptive booklets and/or union agreements provided by the University for more information.

Special Enrollment Rights. If you are declining enrollment in medical coverage for yourself and/or your spouse and Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your spouse and Dependents in health coverage under this Plan in the following circumstances:

- if you and/or your spouse and Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage),
- if you or your Dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- if you or your Dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

However, you must request enrollment (i) within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage) including the exhaustion of COBRA coverage, or (ii) within 60 days in the case of changes related to Medicaid or CHIP.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in health coverage under this Plan

or change your medical coverage option. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption (and complete all required applications).

To request special enrollment or obtain more information, contact the Human Resources Department.

Participation Following Cessation of Eligibility

If you terminate employment or otherwise cease to be an eligible employee and again become an eligible employee, you will generally begin participation in the Plan after you first satisfy the participation requirements described above.

CESSATION OF PARTICIPATION

Generally, participation under the Plan will terminate automatically as of (1) the date on which the Plan terminates, (2) the last day of the month in which you terminate employment or otherwise cease to be an eligible employee, (3) the first day of any Plan Year in which you elect not to participate, (4) the date on which you revoke your election on account of and consistent with a "change in status," as described below under "Changing Your Election."

Continuation Coverage

If you terminate your employment with the University, you and/or your dependents or domestic partner may be entitled to continuation coverage under any health care coverage option you have at the time of termination. The section of this booklet entitled "Continuation of Coverage Under COBRA" describes certain circumstances under which you may be able to continue health care coverage for you and/or your dependents or domestic partner beyond the date coverage would otherwise cease.

Authorized Leaves of Absence

The University may continue coverage during certain periods of absence, such as absence by reason of sickness, disability, or other authorized leave of absence (including military leaves), in accordance with its personnel policies and practices and to the extent prescribed by law. If benefits are continued during a period of unpaid leave of absence, your contributions, if any, must be made in accordance with the University's personnel policies and practices.

FAMILY AND MEDICAL LEAVE ACT PROVISIONS

If you take leave under the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke an existing election to participate in the Plan for the remainder of the Plan Year. If you revoke an existing FSA election to participate in the Plan while you are on FMLA leave, you will not be entitled to receive reimbursement from either of FSAs for any claims incurred following your election to revoke participation. If you revoke an existing medical or dental election while you are on FMLA leave, you will not have medical or dental coverage (as applicable) for any portion of your leave following your election to revoke participation. Upon return from such leave, you may choose to be reinstated in the Plan on the same terms as prior to taking FMLA leave, but you may not retroactively elect coverage under the FSAs for claims incurred following your election to revoke participation.

You may also continue to participate in the Plan, including participation in either or both of the two FSAs, during FMLA leave. If your leave is unpaid, you will be responsible for paying your share of any contributions that you were paying while working, under one of the two following options:

Pre-Pay

You may, prior to commencement of the FMLA leave, pay the amounts due for any portion of the leave period. Contributions may be made on a pre-tax salary reduction basis from any taxable compensation.

Pay-Upon-Return

At the discretion of the Plan Administrator and with prior written agreement, you may pay the amounts due for the entire leave period after your return from FMLA leave. Contributions may be made on a

pre- tax salary reduction basis from any taxable compensation (including the cashing out of unused sick or vacation days) and may be made in one lump sum payment or spread out over several payroll periods.

If you terminate employment before repaying the full amount of any contributions owed, the applicable amount will be deducted from any unused vacation days. In addition, If you have previously revoked an election to participate in the Plan, you will not be entitled to make retroactive payments and receive reimbursement from either of FSAs for claims incurred during the period when coverage was terminated.

BENEFITS

This section briefly summarizes the benefits available under the Plan and describes some important rules regarding your annual elections. If you have any questions about the enrollment process or any of the options available to you, please contact the Human Resources Department.

Paying for Coverage

The University will make a contribution on behalf of each eligible employee toward the cost of single coverage under any of the medical benefit programs. You will be required to contribute a portion of your compensation, pursuant to a voluntary salary reduction agreement to cover the cost of any coverage that you elect that costs more than the University's contribution. The contribution you are required to pay is determined by the University, in consultation with the AAUP (if applicable), each year and may be adjusted during the year to reflect any increases or decreases. If you are required to make contributions, your contributions will be deducted from your pay, before federal income taxes, state income taxes[1] or Social Security taxes are withheld (some local income/wage taxes may apply), meaning that you purchase coverage with more valuable pre-tax dollars. Therefore, you will be taxed on a slightly lower gross income and your taxes will be lower. Because your pre-tax contributions are not subject to Social Security taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($132,900 for 2019). However, the loss in retirement benefits should be more than offset by the tax savings under the Plan.

Changing Your Election

During each annual open enrollment period, you will be given the opportunity to select your coverage for the upcoming Plan Year. If you do not elect to change your selection from the previous year, the University assumes that you want to continue under the same options, and you will keep your prior year's medical and/or dental elections. However, you will not receive benefits under either the Medical Expense Account or the Dependent Care Expense Account. Generally, federal law prohibits changes to your coverage election during the Plan Year. However, you may make a change to your election if you have a "change in status" (as described below) and the election change is on account of and consistent with the change in status. To change your coverage elections, you must notify the University within 30 days of the change in status and provide any proof of the change as may be required by the University.

Note: Any changes related to a spouse or child(ren) will apply equally to a domestic partner and his or her child(ren).

The following events are considered changes in status:

- Events that change your legal marital status (including marriage, divorce, legal separation, annulment or the death of your spouse);

1 However, if you are a resident of Pennsylvania, your contributions to the Dependent Care Expense Account will be subject to state income taxes. If you are a resident of New Jersey, your contributions to both the Medical Expense Account and the Dependent Care Expense Account, as well as any other pre-tax premium payments that you may make, will be subject to New Jersey state income taxes.

- Events that change the number of your dependents (including birth, adoption or placement for adoption, or the death of a dependent);
- A termination or commencement of employment by you, your spouse, or your child;
- A reduction or increase in hours of employment by you, your spouse or child (including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence);
- A child ceasing to satisfy the definition of "dependent" under the Plan;
- A change in the place of residence or worksite by you, your spouse or child;
- A significant change in the health coverage of you or your dependent due to your spouse's employment (this event does not apply to the Medical Expense Account);
- Other events that will permit a change in your health coverage elections include (1) a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order or "QMCSO") that requires health coverage for your child or foster child, or (2) you, your spouse or child becoming entitled to Medicare benefits;
- A change in the cost of dependent care coverage or a change in the dependent care provider; and
- Any other events that the Plan Administrator determines would permit a change of election under applicable governmental regulations.

If permitted under the applicable insurance contracts, you may be allowed to change health insurance providers during the Plan Year. Normally, such a change may take place only during the open enrollment period prior to each Plan Year. However, you may be permitted to change health coverage where there has been a significant change in the cost or coverage level of your or your spouse's/domestic partner's health coverage during the Plan Year, as determined by the University.

Flexible Spending Accounts

Highlights. FSAs provide valuable benefits designed to give you a tax-effective way to reimburse yourself on a tax-free basis for certain medical care and dependent care expenses. The Medical Expense Account is designed to help you pay certain medical care expenses that you and your family may incur. The Dependent Care Expense Account is intended to qualify as a dependent care assistance benefit within the meaning of Section 129 of the Code and help you pay qualified dependent care expenses.

Before the Plan Year begins, or when you first meet the Plan's eligibility requirements, you may elect to have a portion of your pay placed in either or both FSAs on a pre-tax basis. You estimate the amounts that you will require in each account for the year and divide the result by the number of pay periods left in the year. This equal amount will be deducted from your gross pay each pay period ***before taxes***. For the Medical Expense Account, you may contribute an amount not in excess of $2,700 per Plan Year. For the Dependent Care Expense Account, you may contribute an amount not in excess of $5,000 per Plan Year. You can now use "untaxed" money to pay for services that you used to pay for with after-tax dollars.

Remember, it is important that you be conservative when estimating your expenses for the next Plan Year. IRS regulations state that any money set aside in these accounts not used for expenses incurred during the same year must be ***forfeited***. ***ANY UNUSED DOLLARS CANNOT BE RETURNED TO YOU***. This is the "use it or lose it" rule required by the IRS. Please not that you will not be entitled to receive interest or any other earnings on contributions allocated to your FSA(s).

In summary:

- Dollars you place in an FSA are taken out of your pay before they are taxed.
- The money in an FSA can only be used to reimburse eligible expenses incurred in the same Plan Year while you were an active participant.
- You will not be entitled to receive interest or any other earnings on contributions made to your FSA(s).
- Money in one FSA cannot be used to pay for items covered by the other FSA nor can money in one FSA be transferred to the other FSA.
- Claims are paid on a monthly basis or, as reasonably, soon thereafter.
- You have up to ninety (90) days following the end of a Plan Year to submit claims to either FSA for expenses incurred during that Plan Year. If you terminate your employment, you will have up to ninety (90) days to submit claims for expenses incurred during the Plan Year but before your date of termination (unless you elect COBRA for your Medical Expense Account).

Here are a few other key considerations to keep in mind when evaluating and planning participation in your FSA:

- Your eligible and ***predictable*** health care expenses;
- Your eligible child-care expenses;
- Your gross income (including your spouse's income) and tax bracket; and
- Your ability to afford a reduction in your paycheck, since part of your salary is set aside for expenses.

Medical Expense Account. The Medical Expense Account may be used to pay any health care expense that qualifies as a medical deduction under IRS rules, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the employer of your spouse or dependent) and long term care insurance. The expenses covered must be for "medical care" under applicable federal law to qualify. Of course, health care expenses reimbursed through your Medical Expense Account cannot be claimed as an additional deduction for income tax purposes. In general, an expense must be incurred before you can request reimbursement. An expense is incurred when the service that causes the expense is provided, not when the expense was paid. You may not be reimbursed for any expenses incurred before your Medical Expense Account coverage became effective or for any expense incurred after your participation ceases. However, a special rule applies to expenses for orthodontia services if you pay for such services in advance of the actual services in order to receive those services. In this case, orthodontia services are deemed to be incurred when you make the advance payment, allowing you to receive reimbursement before all services have been rendered.

You can use the Medical Care Expense Account to reimburse yourself for expenses incurred by (i) you, (ii) your spouse, (iii) your child, adopted child, stepchild or foster child through the end of the calendar year in which they attain age 26, (iv) a "qualifying child" (as defined below) or (v) a "qualifying relative" (as defined below). Expenses for a domestic partner are not eligible unless the domestic partner (or his or her children) is your qualifying relative.

- A "qualifying child" is a child who meets the following requirements:
  - the child is your child, adopted child, stepchild, foster child, grandchild, brother, stepbrother, sister, stepsister, niece or nephew;
  - the child lives with you for more than one-half of the year;
  - the child has not attained age 27 as of the close of the year (Note: This age limit does not apply in the case of a child who is permanently and totally disabled), and

- the child does not provide over one-half of his or her own support for the year.

- A "qualifying relative" is an individual who meets the following requirements:
  - the individual is your child, adopted child, stepchild, foster child, grandchild, parent, grandparent, brother, stepbrother, sister, stepsister, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law (Note: this requirement is also met if the individual does not have one of these specified relationships to you, but the individual lives with you and the relationship between you and that individual is not in violation of local law);
  - you provide over one-half of the individual's support for the year; and
  - the individual is not a qualifying child (as defined above) of you or any other taxpayer for the year.

For purposes of these determinations, special support and residency rules apply for separated or divorced parents. Contact the Plan Administrator or your tax advisor for more information.

Eligible Expenses. Sample health care expenses include, but are not limited to:

- Deductibles and co-payments;
- Medical expenses not covered by any insurance;
- Dental expenses not covered by any insurance;
- Vision expenses not covered by any insurance;
- Prescription drug expenses not covered by any insurance;
- Non-prescription medicines and drugs for which you have a prescription;
- Smoking cessation program charges;
- Ambulance fees;
- Chiropractic services;
- Oral contraceptives;
- Contact lenses;
- Hearing aids;
- Infertility services;
- Wheelchairs;
- Prosthetics; and
- Durable medical equipment

Ineligible Expenses. In general, any expenses that cannot be claimed as medical expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- Premiums for health insurance or long term care insurance;
- Cosmetic surgery (except in limited circumstances);
- Electrolysis;
- Health Club dues not related to a specific medical condition;

- Non-prescription items (such as vitamins) that are merely beneficial for your or your dependent's general health;
- Weight loss programs;
- Dental bonding and bleaching;
- Services for which any insurance reimburses you; and
- Services rendered before the starting date or after the ending date of your entry into the plan.

Refer to IRS Publication 502, "Medical and Dental Expenses," for more information regarding eligible and ineligible medical expenses.

Dependent Care Expense Account. The Dependent Care Expense Account is designed to help you pay for dependent care services for the following individuals:

- your, child, grandchild, brother or sister who is under age 13, who resides in your household for more than one-half of the year and who does not provide more than one-half of his or her own support for the year;
- a disabled spouse who resides in your household for more than one-half of the year; and
- a disabled relative or household member who is principally dependent on you for support, who resides in your household for more than one-half of the year. (This could include a domestic partner.)

In general, an expense must be incurred before you can request reimbursement. An expense is incurred when the service that causes the expense is provided, not when the expense was paid. You may not be reimbursed for any expenses incurred before your Dependent Care Expense Account coverage became effective or for any expense incurred after your participation ceases.

You can use the Dependent Care Expense Account to reimburse yourself for eligible expenses directly related to the "well-being and protection" of an individual described above if those expenses are necessary for you to work. If you are married, your spouse must also be employed (or seeking employment), enrolled as a full-time student, or disabled for your expenses to qualify. Expenses incurred while you are not working (e.g., sick day, vacation, etc.) do not qualify for reimbursement; provided, however, that care provided during certain "short" or "temporary" absences for illness or vacation may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis. Any type of dependent care that you could legally claim if you were filing for credit on your income taxes is eligible for funding under the Dependent Care Expense Account. However, you cannot claim a credit for any expense that was reimbursed under the dependent care FSA.

Qualifications for Dependent Care Expense Account. You qualify to use this account if:

- You are a single parent;
- You have a working spouse;
- Your spouse is a full-time student for at least five (5) months during the year you are working; or
- Your spouse or other adult dependent is disabled and unable to provide for their own care.

Eligible Expenses. Eligible dependent care expenses include:

- services provided to care for eligible dependents while you are at work, as long as the provider submits a tax ID or social security number
- household services, if attributable to the care of your dependent

- the services of a day care center (if the center provides care for more than six individuals, other than residents, it must comply with all applicable state and local laws)
- the services at a day camp, including a camp that specializes in a particular activity (such as a soccer or computer camp)
- care for a disabled dependent provided outside your home as long as the dependent is a child under age 13 or is in your home for at least eight hours a day
- certain education expenses—for example, the cost of nursery school, including lunches—if your child is not yet in the first grade. (Note: Kindergarten expense reimbursement requests will be approved to the extent that the request shows that a portion of a kindergarten expense was primarily for the care (and not the education) of a dependent child. Reimbursement requests marked simply as "kindergarten" expenses will not be approved.)
- expenses for care provided in your home, as long as the care is not provided by someone you or your spouse claims as a dependent on your federal income tax return, or your child who is under age 19 (even if you no longer claim that child as a dependent)
- agency fees, application fees or deposits, if you are required to pay these expenses in order to obtain the related care

To make sure your situation and the type of care being provided meets IRS requirements, refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses." In addition, you should know that if you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications are available on the IRS' website (www.irs.gov), and also should be available at your local post office or public library.

Ineligible Expenses. Here are some examples of expenses that are not eligible for reimbursement through the Dependent Care Expense Account:

- non-employment related care, such as babysitting fees during non-working hours or expenses incurred on days when you (or your spouse) are not working due to vacation or illness; provided, however, that care provided during certain "short" or "temporary" absences for illness of vacation may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis
- transportation expenses (other than transportation expenses that are incurred by a dependent care provider)
- convalescent or nursing home expenses for a parent or disabled spouse
- overnight camp expenses
- educational expenses for a child in the first grade or above
- dependent care expenses that enable you or your spouse to do volunteer work

Maximum Tax-Free Reimbursement. Generally, amounts reimbursed from your Dependent Care Expense Account are tax-free to you. However, federal law states that the amount excluded from your gross income cannot exceed, in any calendar year (under all dependent care plans in which you or your spouse may participate) the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or

- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally disabled, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or 12 times the assumed monthly income amounts of either $250 or $500. By making an election under the Plan to contribute to a Dependent Care Expense Account, you are representing to the University that your contributions to the Account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) separated for more than six (6) months and pay for more than half of the household expenses.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. You should make your care provider aware of this reporting requirement.

Federal Dependent Care Tax Credit. Dependent care expenses for which you are reimbursed from your Dependent Care Expense Account will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care Expense Account. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a Dependent Care Expense Account in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not subject to federal income tax, and is not subject to Social Security withholding tax (FICA) (7.65% up to $132,900 for 2019). If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.

Federal Earned Income Credit. Another tax credit available under current tax law is the earned income credit. This credit also reduces the federal tax you have to pay on a dollar-for-dollar basis, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the Plan for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the Dependent Care Expense Account may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

How to File for Reimbursement from the Flexible Spending Accounts. Unless the Automatic Payment Option (see below) is in effect, when you want to be reimbursed for expenses, you must submit the appropriate claim forms and supporting documentation to the provider whose name and address appears on the claim form. These forms are available from the Human Resources Department. This form must be accompanied by copies of bills, invoices, or other statements showing a description of

the service provided, the date of service, and the amount of the expense, together with any additional documentation that may be required. Generally, claims are paid on a weekly basis or reasonably soon thereafter. Remember, an incomplete claim form increases the amount of time required to send you your reimbursement check.

Expenses under the Medical Expense Account will be reimbursed in full up to the amount of your yearly election, less any claim amounts previously reimbursed. Expenses under the Dependent Care Expense Account will be reimbursed up to your current account balance. **Note**: Upon termination of employment, you will be eligible to receive reimbursement from the Medical Expense Account for the full amount of your yearly election (less any claims already reimbursed) for all medical expenses incurred as of the date of your termination. However, you will only be eligible to receive reimbursement from the Dependent Care Expense Account for dependent care expenses currently funded as of the date of your termination.

Medical Expense Account Automatic Payment Option. If you are covered by an Aetna health plan option, you can enroll in an automatic payment option ("Streamline") that allows you to have medical expenses automatically considered for reimbursement by your Medical Expense Account. Each time you submit a claim to Aetna for payment, any unreimbursed expenses are sent automatically to the Medical Expense Account system for processing. You do not have to submit a claim form in most instances. (If Aetna cannot process a claim automatically, you will receive a request from Aetna to submit a paper claim.)

Another feature simplifies the Medical Expense Account reimbursement process for prescription drugs. When you fill a prescription at a participating Aetna pharmacy, show your Aetna ID card. Your prescription drug copay will be drawn from your Medical Expense Account balance. You pay nothing out of your pocket at the time you purchase the prescription, and you do not have to submit a claim form.

Important Notes:

- If you are eligible for coverage under another health care plan, the other plan(s) must also consider any expense before it is submitted for reimbursement by your Medical Expense Account. You should therefore submit paper claims; these automatic payment options are not appropriate for your situation.
- Also, because your domestic partner (or his or her children) may not be your "qualifying relative" or "qualifying child" (see definitions above) eligible for coverage under the Medical Expense Account, the automatic payment feature will not apply to these individuals even if they are covered under an Aetna health plan option. You must submit paper claims for expenses for such individuals.

Privacy of Health Information

The receipt, use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure.

CLAIMS PROCEDURE

The booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate

claims and appeals procedures will be very similar in most respects, there may be important differences. Accordingly, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims) shall be referred to as the "Claims Administrator" at the initial claim level and the "Plan Administrator" at the appeal level.

A request for benefits is a "claim" subject to these procedures only if it is filed by you or your authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing with the Claims Administrator, as follows:

Aetna
P.O. Box 4000
Richmond, KY 40476-4000
Phone: 877.392.3862
Fax: 888.238.3539

Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section below. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Plan Administrator identifying such authorized representative.

Benefits are paid from the University's general assets and are not guaranteed under the contract with Aetna.

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under the Medical Expense Account, the Claims Administrator will respond to your claim within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

If you bring a claim for benefits under the Dependent Care Expense Account, the Claims Administrator will respond to you within 90 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of Any Internal Rules – with regard to a claim for benefits under the Medical Expense Account, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

Appealing a Denied Claim for Benefits

If your initial claim for benefits under the Medical Expense Account is denied by the Claims Administrator, you may appeal the denial by filing a written request with the Plan Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Plan Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

If your initial claim for benefits under the Dependent Care Expense Account is denied by the Claims Administrator, you may appeal the denial by filing a written request with the Claims Administrator within 60 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Plan Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits under the Medical Expense Account, the Plan Administrator will respond to your claim within 60 days after receipt of the appeal.

If you bring a claim for benefits under the Dependent Care Expense Account, the Claims Administrator will respond to you within 60 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 60-day period that the Claims Administrator needs up to an additional 60 days to review your claim.

Notice and Information Contained in Notice Denying Appeal

If the Claims Administrator denies your claim (in whole or in part), the Plan Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of Any Internal Rules – with regard to a claim for benefits under the Medical Expense Account, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Plan Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

- Statute of Limitations - Any lawsuit seeking benefits under this Plan must be brought within two years of when you or your representative (as applicable) knows or should have known that a claim for benefits has been, or likely would be, denied. To be clear, the two year period starts running from the earliest possible date of those described above. In the event that you do not submit a claim for benefits by the "Claim Deadline" applicable to a particular benefit, then the claim shall be deemed denied as of the Claim Deadline and the two year Statute of Limitations shall begin to run from the Claim Deadline.

Governing Law, Jurisdiction and Venue - The Plan will be governed by the laws of the State of New Jersey, except where preempted by ERISA. Exclusive jurisdiction and venue of all disputes arising out of and relating to the Plan, matters of Plan interpretation or factual determinations made by the Plan Administrator or its delegates is in any court of appropriate jurisdiction in Trenton, New Jersey.

CONTINUATION OF COVERAGE UNDER COBRA

Proposed regulations issued by the IRS provide that continuation of coverage rights under the COBRA are applicable with respect to health care reimbursement arrangements, such as the Medical Expense Account. Accordingly, you will find a COBRA notice in Appendix A of this booklet. Please be aware that any contributions you make under the Medical Expense Account pursuant to COBRA will be made on an after-tax basis at a rate of 102% of the amount available for reimbursement. Therefore, the chief advantage of participating in the Plan – that is, the tax savings attributable to payment of qualifying expenses with pre-tax dollars – will not be available to you. If you elect continuation coverage under COBRA, you will continue to be eligible to receive reimbursement up to the full amount elected for the Plan Year and will continue to make premium payments (at 102% of the elected amount). If you do not elect COBRA, your participation will cease.

PLAN ADMINISTRATOR

The Plan Administrator within the meaning of ERISA is the Chief Human Resources Officer whose business address is provided under "Additional Information" below. Benefits under the Plan are administered by the Plan Administrator in accordance with contracts the University has entered into with various insurance companies and other providers or administrators of health benefits. All matters

relating to the administration of the Plan, including the duties imposed upon the Plan Administrator by law and the interpretation of the Plan provisions are the responsibility of the Plan Administrator. In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, consistent with the appropriate collective bargaining agreement provisions, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits except where such decisions would be in conflict with such collective bargaining unit provisions. The Plan Administrator has the authority, in the Plan Administrator's sole discretion, to interpret the Plan and resolve ambiguities therein, to develop rules and regulations to carry out the provisions of the Plan, and to make factual determinations. Nothing in the foregoing should be construed to supersede the provisions of any existing collective bargaining agreement.

However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Sponsor has delegated certain administrative and claim review functions under the Plan to the benefit providers. As the Plan Administrator's delegate, the benefit providers have the authority to make all decisions under the Plan relating to benefit claims.

The decisions of the Plan Administrator (or his/her delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

AMENDMENT OR TERMINATION OF THE PLAN

The Board of Trustees of the University reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents without further action by the University's Board of Trustees except where such action is subject to the provisions of a collective bargaining agreement. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or copayments, (4) change the class(es) of employees and/or dependents covered by the Plan, and (5) change benefit providers. The University also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination or partial termination.

ADDITIONAL INFORMATION

Plan Information

The official plan name, plan identification number, and Plan Year (fiscal year used for plan records) for the Plan are as follows:

Plan Name:	Rider University Pre-Tax Premium and Flexible Spending Accounts Plan
Plan Number:	509
Plan Year:	The twelve (12) month period commencing January 1 and ending December 31.
Type of Plan:	The Plan is a welfare benefit plan providing the following types of benefits:

(1) Medical Expense Account (this is a "group health plan" for purposes of federal law)

(2) Dependent Care Expense Account

University/Plan Sponsor Information

The name, address and telephone number of the University/Plan Sponsor are as follows:

Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648-3099

Employer Identification Number ("EIN")

The employer identification number assigned to the University by the IRS is as follows:

21-0650678

Plan Administrator Information

The name and business address of the Plan Administrator are as follows:

Chief Human Resources Officer
Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648-3099

Agent for Service of Legal Process

The agent for the service of legal process for the Plan is the Plan Administrator, at the address set forth above.

NONDISCRIMINATION

Contributions and benefits under the Plan will not discriminate in favor of "Highly Compensated Employees" or "Key Employees." The University may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

LOSS OF BENEFITS

Except as might otherwise be described in the booklets explaining your medical options, your coverage generally ends as of the last day of the month following employment termination or loss of eligibility. This will occur upon your retirement, resignation, discharge or death. The University will, however, discuss with you at your request what, if any, arrangements may be made to continue coverage beyond the date your employment ceases. The section of this summary entitled "Continuation of Coverage Under COBRA" also describes certain circumstances under which health care coverage may be continued beyond the date your employment ceases or, in the case of your dependents, beyond the date they are eligible for health care coverage under the Plan.

NO ASSIGNMENT OR ALIENATION OF BENEFITS

Benefits payable under this Plan may not be assigned, transferred or in any way made over to another party by a participant or beneficiary for any reason. The Plan will not recognize any assignment of any rights under this Plan or ERISA, and any attempt to assign such rights shall be void. The payment of benefits directly to a health care or other provider, if any, shall be done as a convenience to you and shall not make the provider an assignee. In no event shall any provider of benefits be a "participant" or "beneficiary" under the Plan and no provider shall have standing under ERISA or the claims procedures of this Plan. Neither the Employer nor the Plan shall be in any manner liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

If a qualified medical child support order ("QMCSO") issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- name and last known address of each child to be covered under this Plan;

- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that 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 the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, 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 NW, 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.

APPENDIX A – COBRA NOTICE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a Federal law that has several provisions designed to protect you and your eligible dependents against a sudden loss of health care coverage if you have a qualifying event that would cause the loss of your health care coverage under the Plan. The following information outlines the continuation of coverage available under COBRA.

General Explanation of COBRA Continuation Coverage

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of health care coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called COBRA continuation coverage. Individuals who are eligible for COBRA continuation coverage are called qualified beneficiaries. The events which entitle qualified beneficiaries to coverage are called qualifying events. In addition, a child born to, adopted by, or placed for adoption with the covered employee during the COBRA continuation coverage period will be a qualified beneficiary for COBRA purposes. To be a qualified beneficiary for a specific type of health coverage (i.e., medical, dental, or Medical Expense Account), you must have had that particular coverage under the Plan on the day before a qualifying event occurs.

Who Must Provide Notice When Coverage is Lost

When a qualifying event occurs, you and the University have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or a covered dependent must notify the Plan Administrator in writing within 60 days of the qualifying event. The University will notify the Plan Administrator within 30 days if the event is death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

Once the Plan Administrator is notified of a qualifying event, the Plan Administrator or its designee will send you and/or your dependents a written explanation of the right to elect COBRA continuation coverage within 30 days. You then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which your existing coverage would end to notify the Plan Administrator of your election. If you and/or a dependent do not respond in writing within the time limit, the right to elect to COBRA continue coverage will be lost and will not be reinstated.

The chart below summarizes who is eligible for COBRA continuation coverage under COBRA, under what circumstances, and for how long.

*******IMPORTANT NOTE: Coverage under the Medical Expense Account will not continue beyond the Plan Year in which the qualifying event occurs.***

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment Termination of employment for reasons other than gross misconduct	18 months* 18 months*
Covered Spouse of an Employee	Death of employee	36 months
	Divorce or legal separation from employee	36 months
	Employee becomes entitled to Medicare benefits	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Covered Child of an Employee	Death of employee	36 months
	Divorce or legal separation of employee and Spouse	36 months
	Employee becomes entitled to Medicare benefits Failure of child to qualify as a dependent under the Plan	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*

* The 18-month COBRA continuation coverage period will be extended to 29 months for all qualified beneficiaries if any qualified beneficiary is disabled under the Social Security laws at any time during the first 60 days of COBRA continuation coverage. To qualify for this extension, the qualified beneficiary must notify the Plan Administrator and provide proof that he or she is disabled under the Social Security laws before the expiration of the 18-month period. The Plan Administrator is permitted to charge a higher premium for COBRA continuation coverage during the 19th through 29th months. If the qualified beneficiary finds that he or she is no longer disabled, he or she must notify the Plan Administrator within 30 days of such a determination.

The 18, 29, or 36 months of COBRA continuation coverage begin on the date that coverage would originally end.

If You Elect to Continue Coverage

Each qualified beneficiary who is eligible to elect COBRA continuation coverage may make a separate election to continue coverage, or one qualified beneficiary may make an election that covers some or all of the other qualified beneficiaries.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or any higher charge that may be permitted by law, such as during the extended coverage on account of disability). The total premium includes both the University's contribution and any contribution that an active participant would be required to make under the Plan for the same coverage. The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for each month after your election are due by the 1st day of the month and must be paid not later than the last day of that month. Premium rates will change periodically for all qualified beneficiaries if costs to the University change. COBRA continuation coverage will be identical to the coverage provided similarly-situated employees and/or dependents. Your health care coverage will continue to be provided by the insurer or other provider which is providing benefits to you on the date of the qualifying event (subject to any residency requirements that may apply). You will have an opportunity to change coverage options during the enrollment period prior to each Plan Year. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

Coverage You May Elect

You may elect to continue medical coverage only, dental coverage only, or Medical Expense Account coverage only, or any combination of these coverages. You may elect to continue only those coverages that were in effect for you on the date of your qualifying event. Since dependent care is not health care benefits protected by COBRA, you may not elect COBRA continuation coverage of that benefit under the Plan.

Coverage for Eligible Dependents

If you elect COBRA continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of coverage until the enrollment period prior to the next Plan Year. At that time, they may change their coverage if they wish. However, if you continue

some, but not all, of the coverages to which you are entitled, or if you decide not to continue your coverage at all, each dependent may make an independent coverage selection.

Changes to COBRA Continuation Coverage

Qualified beneficiaries have the same opportunities to change coverage as active employees during the enrollment period prior to each Plan Year. During each enrollment period, you may elect different coverage or add or delete dependents in the same manner as an active employee.

If You Have Region-Specific Coverage

If you are enrolled in a region-specific coverage option (such as an HMO) on the day before your qualifying event occurs, you may elect COBRA continuation coverage. However, you must remain in that coverage until the enrollment period prior to the next Plan Year, at which time you may change coverage if you so wish. If you move out of the service area during your period of COBRA continuation coverage, you may be able to elect alternate coverage.

When COBRA Benefits End

Generally, COBRA continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA continuation coverage will end immediately if:

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation which does not apply to (or is satisfied by) the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, entitled to Medicare benefits;
- In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the disabled person is no longer disabled under the Social Security laws; or
- The University no longer maintains a group health plan covering any employee.

Two Qualifying Events

An 18-month period of COBRA continuation coverage may be extended if another qualifying event occurs during that time. However, no one may extend coverage for more than 36 months from the occurrence of the first qualifying event. For example, if your employment ends and you get divorced during the initial 18-month continuation period, your dependents (but not you) may extend coverage for up to 36 months from the date your employment ended. If the covered employee becomes entitled to Medicare benefits and during the subsequent 18-month period loses coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than the employee will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement, subject to the rules regarding earlier termination of COBRA coverage.

Continuation Coverage During Military Service

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (also referred to as "USERRA") may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

Conversion to an Individual Policy

At the end of the 18, 29, or 36-month COBRA continuation coverage period, you may be eligible to convert your coverage to an individual policy. If you are eligible, you will be required to make the necessary arrangements directly with the insurance carriers. The necessary information should be contained in the materials provided by the insurance carriers. If not, you should check with you're a benefit representative from the Human Resources Department. Conversion coverage may not be the same as the coverage you have under the Plan. Instead, it will be one of the insurance carrier's standard conversion policies. There is no conversion option applicable to the Medical Expense Account.