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Institute on Aging

Health and Welfare Benefits Plan

# Master Summary Plan Description

Amended/Restated Effective January 1, 2022

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

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

**This Wrap Summary Plan Document (SPD)  
has been formally modified through the  
Summary of Material Modification  
document(s) attached at the back of this  
document.**

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## 1. Definitions

Capitalized terms used in this document have the following meanings:

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

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

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

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

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

**"DCAP"** means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

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

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

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

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

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

**"Plan"** means the Company Welfare Benefits Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

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

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

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

## 2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a “Benefit Description”). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

## 3. General Information about the Plan

<b>Plan Name:</b>	Institute on Aging Health and Welfare Benefits Plan.
<b>Type of Plan:</b>	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
<b>Plan Year:</b>	January 1 to December 31.
<b>Plan Number:</b>	504
<b>Effective Date:</b>	January 1, 1999. The Plan has been amended several times since its original effective date, most recently as of January 1, 2022.
<b>Funding Medium and Type of Plan Administration:</b>	<p>Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured.</p> <p>For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO.</p> <p>The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.</p> <p>For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The</p>

Company may hire a third party administrator (a "TPA") to process claims.

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

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

**Plan Sponsor:**

The employer is the Plan Sponsor.

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
  
415-750-4122

**Plan Sponsor's Employer  
Identification Number:**

94-2978977

**Insurance Companies/HMO:**

See a complete list under the heading Plan Provider Information later in this document.

**Plan Administrator:**

Attention: Human Resources Director  
Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
  
415-750-8747

**Named Fiduciary:**

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
  
415-750-8747

**Agent for Service of Legal  
Process:**

Human Resources Manager  
  
Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
  
415-750-8747

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

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact Human Resources at 415-750-8747.

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

## 4. Eligibility and Participation Requirements

### Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage.

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

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.**

### Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

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

## Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the monthly method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

## Special Enrollment Provisions under HIPAA

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

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

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

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

## Coverage during Certain Leaves of Absence

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

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

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

## **Terms of Participation**

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

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

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

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

## **COBRA Rights**

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-



funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

## **5. Summary of Plan Benefits**

### **Benefits and Contribution**

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

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

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual

notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

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

#### **Newborns' and Mothers' Health Protection Act (NMHPA) of 1996**

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

#### **Women's Health and Cancer Rights Act (WHCRA) of 1998**

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

#### **Qualified Medical Child Support Orders**

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

#### **Lifetime and Annual Limits**

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

## **6. Grandfathered Status under the Affordable Care Act**

### **Non-Grandfathered Benefit Programs under the Affordable Care Act**

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

- Kaiser HMO California
- Kaiser HMO Oregon
- UHC PPO

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

#### **Preventive Services covered at 100%**

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

#### **Non-Network Emergency Services covered as In-Network**

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

#### **Access to Primary Care Physicians**

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

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

## **7. How the Plan Is Administered**

### **Plan Administration**

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

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

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

### **Power and Authority of Insurance Company**

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

### **Questions**

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

## **8. Circumstances Which May Affect Benefits**

### **Denial or Loss of Benefits**

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

**Right to Recover Benefit Overpayments and Other Erroneous Payments**

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

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

**9. Amendment or Termination of the Plan****Amendment or Termination**

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

**10. No Contract of Employment**

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

## **11. No Assignment**

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

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

## **12. Claims Procedure**

### **Claims for Fully-Insured Benefits**

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

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

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

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

### **Claims for Self-Funded Benefits**

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

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

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

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

### **The Role of Authorized Representatives**

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

## **13. Statement of ERISA Rights**

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

### **Your Rights**

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

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the

documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### **Fiduciary Obligations**

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

### **No Discrimination**

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

### **Right to Review**

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

### **Filing Suit**

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

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

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

### **Questions**

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



## **14. General Information**

### **COBRA**

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please contact Human Resources. You may also have state law continuation or conversion rights.

### **Subrogation and Reimbursement**

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

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

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

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

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

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

### **No Vesting of Benefits**

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

### **Waiver and Estoppel**

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

### **Effect on Other Benefit Plans**

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

### **Severability**

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

### **Rebates**

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

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

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

### **Controlling Law**

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

## 15. Benefit Program Information

### Summary of Eligibility and Participation Provisions

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

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Medical HMO</b>	Fully-Insured / Kaiser Permanente California	603152	Full time employees working 30+ hours per week. Spouses and children generally are covered.	First day of the month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Kaiser Permanente CA at: P.O. Box 12923 Oakland, CA 94604-2923 (800) 464-4000
<b>Medical PPO</b>	Fully Insured / United Health Care	924262	Full time employees working 30+ hours per week. Spouses and children generally are covered.	First day of the month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	UHC at: P.O. Box 30555 Salt Lake City, UT, 84130-0555 (866) 633-2446
<b>Health FSA</b>	Self-Funded	N/A	Full time employees working 30+ hours per week. Expenses of spouses and children generally can be reimbursed at employee election.	First day of the month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available unless Health FSA is "overspent."	Accrue CMS P.O. Box 2167 Omaha, NE 68103 1-866-517-7580

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

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Employee Assistance Program</b>	Fully Insured / Concern EAP	123367	Full time employees working 30+ hours per week	First day of month immediately after hire date	Immediately upon termination of employment.	Member Services 1503 Grant Road Suite120 Mountain View, CA 94040 800-344-4222
<b>Dental PPO</b>	Fully Insured / Mutual of Omaha	G000BW2Y	Full time employees working 30+ hours per week. Spouses and children generally are covered.	First day of month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Member Services P.O. Box 211472 Eagan, MN 55121 (800) 927-9197
<b>Vision</b>	Fully Insured / Mutual of Omaha	G000BW2Y	Full time employees working 30+ hours per week. Spouses and children generally are covered.	First day of month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Member Services P.O. Box 8504 Mason, OH 45040 (833) 279-4358
<b>Life, AD&amp;D and Disability</b>	Fully Insured / Mutual of Omaha	G000BW2Y	Full time employees working 30+ hours per week	First day of month immediately after hire date and proper election.	Immediately upon termination of employment.	Member Services 3300 Mutual of Omaha Plaza Omaha, NE 68175 Life/AD&D: (800) 775-8805 Disability: (800) 877-5176
<b>Critical Illness and Accident</b>	Fully Insured / Mutual of Omaha	G000BW2Y	Full time employees working 30+ hours per week. Spouses and children generally are covered.	First day of the month immediately after hire date and proper election.	End of the month in which coverage is dropped or employment is terminated.	Member Services 3300 Mutual of Omaha Plaza Omaha, NE 68175 (800) 775-8805

<b>Benefit Program</b>	<b>Fully-insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Reimbursement</b>	Self Insured / Difference Card	N/A	Full time employees working 30+ hours per week	First day of month immediately after hire date	Immediately upon termination of employment.	Difference Card at: 245 Main Street Suite 605 White Plains, NY 10601 (888) 343-2110
<b>HCSO</b>	Fully Insured / Boon	IOA	Full time employees working 30+ hours per week.	First of the month following 90 days of employment.	End of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Boon Member Services at: (866) 868-4139



## Appendix A: COBRA Continuation

### GENERAL NOTICE OF YOUR RIGHTS GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

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

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

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you, your spouse, and dependent children when coverage under the Plan would otherwise end. This notice explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. This notice does not fully describe COBRA coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's summary plan description or contact the Plan administrator. COBRA coverage must be offered to each person losing 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 Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this notice is intended to expand your rights beyond COBRA's requirements under the Institute on Aging Group Health Plan. For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the Institute on Aging Plan Administrator at (415) 750-4111. Also, you may visit the Department of Labor website ([www.dol.gov](http://www.dol.gov)) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

#### 1. You Must Give Notice of Some Qualifying Events

For certain 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 Institute on Aging in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. If the notice is not provided to the Plan Administrator during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

#### 2. Qualifying Events

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

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

1. The death of your spouse;
1. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with Institute on Aging;
2. Divorce or legal separation 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.
3. Your spouse becomes entitled to Medicare.

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

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

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

### **3. You may have other options available to you when you lose group health coverage**

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

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

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

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

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

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

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

### **5. How Long Does COBRA Coverage Last?**

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





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

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

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

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

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

## **6. Coverage Provided**

Under COBRA, the employee or a family member has the responsibility to inform the Institute on Aging Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. Institute on Aging has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the Institute on Aging Plan Administrator that you want to continue coverage under COBRA. If these procedures are not followed or if the notice is not provided during the 60-day notice period, then all qualified beneficiaries will lose their right to elect COBRA.

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

## **7. Period of Coverage**

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

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the Institute on Aging Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Institute on Aging Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

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



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

If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

8. Divorce or legal separation
9. Death
10. Medicare entitlement
11. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the Institute on Aging Plan Administrator within 60 days of the event or there will be no extension of COBRA coverage. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA. This extension may be available to the spouse and any dependent children getting COBRA coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)



## 12. Health FSA Information

COBRA coverage under the Institute on Aging Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Institute on Aging Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Institute on Aging Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Institute on Aging Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Accrue Solutions at (469) 384-7600 during business hours for more information.

## 13. Alternate Recipients Under QMCSOs

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

## 14. Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## 15. Plan Contact Information

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

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (469) 384-7600 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (469) 384-7600 during business hours.

Sincerely,

Accrue Solutions

**NOTICE OF SPECIAL ENROLLMENT RIGHTS**

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

If you have any questions, please contact our Customer Service Department at (469) 384-7600 during business hours

## Appendix B: Medicare Part D

# Medicare Part D Notice

### Important Notice from Institute on Aging About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
  2. Institute on Aging has determined that the prescription drug coverage offered by the Institute on Aging Health and Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- 

#### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

#### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Institute on Aging coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Institute on Aging Health and Welfare Benefits Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Institute on Aging prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Institute on Aging and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Institute on Aging changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	June 1, 2021
Name of Entity/Sender:	Institute on Aging
Contact-Position/Office:	Human Resources
Address:	3575 Geary Blvd. San Francisco, CA 94118
Phone Number:	415-750-8747

## **Appendix C: Cafeteria Plan and FSA Provisions**



## Institute on Aging

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118

### Institute on Aging FSA Plan

#### Plan Document

Amended and Restated July 01, 2020



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## INTRODUCTION

The company amends and restates this Plan as of July 01, 2020 with an original effective date of July 01, 2019. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the Institute on Aging FSA Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

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## I. ARTICLE - PLAN DEFINITIONS

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01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including but not limited to the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.
02. **"Benefit" or "Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".
03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.
04. **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.
05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.
06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

**"Dependent"** shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means July 01, 2019.
08. **"Election Period"** means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to the Article titled: "Participant Elections".
09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

An "Eligible Employee" shall exclude the following:

- Non-Resident Aliens
- Leased Employees

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

11. **"Employer"** means Institute on Aging and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.
12. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
13. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.
14. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.
15. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.
16. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.
17. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.
18. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.
19. **"Plan Year"** means the 12-month period beginning July 01 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.
20. **"Premium Expenses" or "Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".
21. **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.
22. **"Qualified Reservist"** means a Participant of the plan who is a member of a reserve component such as: the Army National Guard; the Air National Guard; the Army Reserve; the Navy Reserve; the Marine Corps Reserve; the Air Force Reserve; the Coast Guard Reserve; the Reserve Corps of the Public Health Service; or as defined 37 U.S.C Section 101.
23. **"Qualified Reservist Distribution"** means a distribution to a Participant which includes a portion or the balance in the Participant's Health Flexible Spending Account as described in the Article titled: "Qualified Reservist Distribution".
24. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.
25. **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to the Section titled: "Salary Redirection". These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under the Article titled: "Participant Elections".
26. **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.
27. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

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## II. ARTICLE - PARTICIPATION

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### 01. ELIGIBILITY

An individual is eligible to participate in this Plan if the individual:

- a. is an Eligible Employee as defined in the Article titled: "Definitions"
- b. is working an average of 30 hours or more per week or at least 130 hours per month; and
- c. is eligible for the group medical plan

### 02. EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of the next month following your date of hire.

### 03. APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

### 04. TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment";
- b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death"; or
- c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

### 05. TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

- a. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.
- b. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for expenses within 90 days after the date of termination, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.
- c. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.

### 06. REINSTATEMENT OF A FORMER PARTICIPANT

An Employee whose participation terminates and returns to an eligible status less than thirty days later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into

consideration so as not to exceed Plan or IRS maximums.

07. **DEATH**

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

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### **III. ARTICLE - CONTRIBUTIONS TO THE PLAN**

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#### **01. SALARY REDIRECTION**

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

#### **02. APPLICATION OF CONTRIBUTIONS**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

#### **03. PERIODIC CONTRIBUTIONS**

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

#### **04. EMPLOYER CONTRIBUTIONS**

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

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## IV. ARTICLE - BENEFITS

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### 01. BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Medical Plan
- Group Dental Plan
- Group Vision Plan

### 02. HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

### 03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

### 04. HEALTH INSURANCE BENEFIT

- a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.
- b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

### 05. DENTAL INSURANCE BENEFIT

- a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
- b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

### 06. VISION INSURANCE BENEFIT

- a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.
- b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

### 07. NONDISCRIMINATION REQUIREMENTS

- a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible



taxation to Key Employees or a group of employees in whose favor discrimination is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

**08. NON-TAX DEPENDENT COVERAGE**

- a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.
- b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

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## V. ARTICLE - PARTICIPANT ELECTIONS

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### 01. INITIAL ELECTIONS

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

### 02. SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;
- c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

### 03. FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

### 04. CHANGE IN STATUS

- a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual ceases or is decreased under said other plan.

Regardless of the consistency requirement, if the individual, or the individual's Spouse or Dependent, becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. **Legal Marital Status:** events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
2. **Number of Dependents:** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
3. **Employment Status:** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
4. **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
5. **Residency:** A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

- b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.
- c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) that requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):
  1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
  2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.
- d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.
- e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.
- f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- g. **Addition of a new benefit.** Notwithstanding subsection (a), if, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In

addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

- h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
- i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.
- j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).
- k. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant changes from full-time employment (i.e., an average of 30 hours of service per week) to part-time employment (i.e., an average of less than 30 hours of service per week), even if the Participant continues to be eligible for coverage under the group health plan, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in another plan that provides minimum essential coverage and is effective no later than the first day of the second month after the month during which the revocation is effective.
- l. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in a Qualified Health Plan through a Marketplace that is effective no later than the day immediately following the effective date of the revocation.
- m. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

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## VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

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### 01. ESTABLISHMENT OF BENEFIT

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

### 02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below have the following meanings:

- a. **"Health Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by the Participant, his or her Spouse and his or her Dependents may be reimbursed.
- b. **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:
  1. one of the 5 highest paid officers;
  2. a shareholder who owns (or is considered to own, applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
  3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h) (3)(B) for those individuals who are not Participants).
- c. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

- d. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).
- e. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

### 03. FORFEITURES

A Participant in the Health Care Flexible Spending Account may roll over up to \$550.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

### 04. LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is \$2,750.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

**Carryover:** A Participant in the Health Care Flexible Spending Account may roll over up to \$550.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

### 05. NONDISCRIMINATION REQUIREMENTS

- a. **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.
- b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health

Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

#### 06. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

#### 07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

- a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.
- b. **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.
- c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.
- d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after the date of termination.

#### 08. **DEBIT AND CREDIT CARDS**

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

- a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
- b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.
- c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Section titled: "Limitation on Allocations".
- d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
- e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the

rulings and Treasury regulations thereunder, including, but not limited to, the following:

1. Co-payments for doctor and other medical care;
  2. Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;
  3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.
- f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.
- g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
1. Repayment of the improper amount by the Participant;
  2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;
  3. Claims substitution or offset of future claims until the amount is repaid; and
  4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

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## VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

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### 01. ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

### 02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

- a. **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.
- b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.
- c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:
  - 1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;
  - 2. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
  - 3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.
- d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,
  - 1. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;
  - 2. a Dependent or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
  - 3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).
- e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

### 03. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

### 04. INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

### 05. DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

### 06. ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related



Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

#### **07. ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

#### **08. FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

#### **09. LIMITATION ON PAYMENTS**

- a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) and \$5,000.00 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

#### **10. NONDISCRIMINATION REQUIREMENTS**

- a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).
- b. **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of (i) the stock of, or (ii) the capital or profits interest in, the Employer.
- c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination is prohibited by Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

#### **11. COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

#### **12. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- a. The Dependent or Dependents for whom the services were performed;
- b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;
- c. The relationship, if any, of the person performing the services to the Participant;
- d. If the services are being performed by a child of the Participant, the age of the child;
- e. A statement as to where the services were performed;

- f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- g. If the services were being performed in a day care center, a statement:
  - 1. that the day care center complies with all applicable laws and regulations of the state of residence,
  - 2. that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
  - 3. of the amount of fee paid to the provider.
- h. If the Participant is married, a statement containing the following:
  - 1. the Spouse's salary or wages, if he or she is employed, or
  - 2. if the Participant's Spouse is not employed, that
    - i. he or she is incapacitated, or
    - ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.
- i. **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ERISA PROVISIONS

01. CLAIM FOR BENEFITS

- a. **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.
- b. **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after the date of termination. Once a claim is submitted, the following timetable for claims and the rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was 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. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
5. 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.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided with the denial free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a decision on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

- c. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to the Section titled: "Forfeitures", whichever is applicable. Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved

in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

## **02. APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

## **03. NAMED FIDUCIARY**

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

## **04. GENERAL FIDUCIARY RESPONSIBILITIES**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

- a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- c. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

## **05. NONASSIGNABILITY OF RIGHTS**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so alienated or subjected shall not be recognized, except to such extent as may be required by law.

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## **IX. ARTICLE - ADMINISTRATION**

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### **01. PLAN ADMINISTRATION**

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

- a. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- b. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- d. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
- f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
- g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such should be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
- h. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and
- i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

### **02. EXAMINATION OF RECORDS**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to their interest under the Plan.

### **03. PAYMENT OF EXPENSES**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

### **04. INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer or other benefit program that is self-insured whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

05. **INDEMNIFICATION OF ADMINISTRATOR**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

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## **X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN**

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### **01. AMENDMENT**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state and local laws, statutes and regulations.

### **02. TERMINATION**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

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## **XI. ARTICLE - MISCELLANEOUS**

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### **01. PLAN INTERPRETATION**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

### **02. GENDER AND NUMBER**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

### **03. WRITTEN DOCUMENT**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

### **04. EXCLUSIVE BENEFIT**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

### **05. PARTICIPANT'S RIGHTS**

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

### **06. ACTION BY THE EMPLOYER**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by the Employer.

### **07. EMPLOYER'S PROTECTIVE CLAUSES**

- a. **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.
- b. **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

### **08. NO GUARANTEE OF TAX CONSEQUENCES**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

### **09. INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

### **10. FUNDING**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.



#### 11. **GOVERNING LAW**

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of California.

#### 12. **SEVERABILITY**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

#### 13. **CAPTIONS**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

#### 14. **CONTINUATION OF COVERAGE (COBRA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

#### 15. **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

#### 16. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

#### 17. **UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

#### 18. **QUALIFIED RESERVIST DISTRIBUTIONS**

Notwithstanding any provision of this Plan to the contrary, a Participant may elect to receive a distribution of certain funds from his or her Health Flexible Spending Account if the following criteria is met:

1. The Participant is a Qualified Reservist as defined in the Section titled: "Definitions".
2. The Participant is ordered or called to active duty for a period in excess of 180 days or more, or for an indefinite period. If the period is less than 180 days, a Qualified Reservist Distribution is not allowed unless there are subsequent orders or calls for duty that increase the total period of active duty to 180 days or more.
3. The Participant has provided the Plan Administrator with a copy of the order or call to active duty and;
4. The request for distribution is made during the period beginning with the order or call to duty and ending on the last day of the Plan Year (or Grace Period if applicable) in which the order or call to duty occurred. The Participant delivers a written election to the Plan Administrator in a form designated or requested by the Plan Administrator.

The amount of the QRD shall be any amount not to exceed the entire amount elected for the current Plan Year minus reimbursements received as of the date of the QRD request.

#### 19. **COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

- a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.
- b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.
- d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to

members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:
  - i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
  - ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
  - iii. mitigation of any harm caused by the breach, to the extent practicable; and
  - iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:
  1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
  2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
  5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
  8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
  9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer 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; and
  10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

## 20. **COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- a. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- b. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- c. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "Compliance with HIPAA Privacy Standards".

21. **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

22. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

23. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

24. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

# Execution Agreement

**IN WITNESS WHEREOF**, Institute on Aging has caused its authorized officer to execute this amended and restated Plan document as of **July 1st, 2019**, the same to be effective **July 01, 2020**, unless otherwise indicated herein.

Institute on Aging

*Kelli Gessner*

Kelli Gessner, HR Operations Director

07/01/2019

1600297022-7622680255

# CERTIFICATE OF RESOLUTION

The undersigned authorized representative of **Institute on Aging** (the Employer) hereby certifies that the following resolutions were duly adopted by the governing body of the Employer on **July 1st, 2019**, and that such resolutions have not been modified or rescinded as of the date hereof:

**RESOLVED**, that the form of amended and restated Welfare Benefit Plan, effective July 01, 2020, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

**RESOLVED**, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

**RESOLVED**, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of Institute on Aging's Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

Institute on Aging



Kelli Gessner, HR Operations Director

07/01/2019

1600297022-7622680255



## Institute on Aging

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118

Institute on Aging FSA Plan

Summary Plan Description

Amended and Restated July 01, 2020

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# Institute on Aging

## Institute on Aging FSA Plan

### INTRODUCTION

The Company's Flexible Benefit Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

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## I. ARTICLE - ELIGIBILITY

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### 01. How can I participate in the Plan?

Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 30 or more hours per week or 130 hours per month and meet the eligibility requirements.

After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

### 02. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and the other eligibility requirements established by your employer as defined in section 1.

### 03. When can I enter the plan?

An Eligible Employee shall become a Participant effective as of the first day of the next month following your date of hire.

### 04. How do I enroll in the Plan?

Before you can join the Plan, you must complete an enrollment form. The enrollment form will allow you to select which benefits you want to participate in under the Plan. This form will also authorize the Company to redirect some of your earnings in order to pay for the benefits you select.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan. These benefits are listed in the Article titled: "Benefits".

## **II. ARTICLE - OPERATION**

### **01. How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

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### III. ARTICLE - CONTRIBUTIONS; ELECTIONS

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#### 01. How much of my pay may the Employer redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

#### 02. What happens to contributions made to the Plan?

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

#### 03. When must I decide which accounts I want to use?

You are required by Federal regulations to decide during the enrollment or election period (defined below) prior to the Plan Year start. You must decide which accounts you want and how much you want to contribute to each account.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance, unless you elect during the election period (defined below) not to participate in the Plan.

#### 04. When is the election period for our Plan?

You will make your initial election on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Company and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Company will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

#### 05. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing

similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse, former spouse or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

In addition, there are laws that give you rights to change group health coverage for you, your spouse, and/or your dependents (i) if you go from working 30 or more hours a week to working less than 30 hours a week and you intend to enroll in certain other health plans, or (ii) if you are eligible to enroll in and intend to enroll in certain Marketplace Qualified Health Plans. If you change coverage due to rights under these laws, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the administrator.

**06. May I make new elections in future Plan Years?**

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Company will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

## IV. ARTICLE - BENEFITS

### 01. What benefits are offered under the Plan?

You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

### 02. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by our insured medical plan, and to save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account for the Plan Year is \$2,750.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. In addition, you may carry over any amount left in your account up to \$550.00. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. This amount can be used the following Plan year to pay for eligible expenses.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified medical expenses. The Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A "child" is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status for purposes of coverage changes.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

### 03. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is \$5,000.00.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000.00 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed annual earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

#### 04. **Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various group insurance programs the Company offers you. These premium expenses include:

- Health care premiums under our insured group medical plan
- Dental insurance premiums
- Vision insurance premiums

Under this Plan, the Company will allocate the pre-tax premium withholding to the accounts established under the Plan pursuant to the Participants' elections. Certain limits on the amount of coverage that can be paid through pre-tax premiums may apply.

The Company may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. The Company will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

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## V. ARTICLE - BENEFIT PAYMENTS

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### 01. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Health Flexible Spending Account or Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

### 02. What happens if I don't spend all Plan contributions during the Plan Year?

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the Employer. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited.

At the end of the Plan Year, and after all eligible reimbursements have been made, any unused funds up to \$550.00 in your Health Flexible Spending Account will roll over into the new Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. Any unused funds left in the account in excess of maximum limit will be forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

### 03. Family and Medical Leave Act (FMLA)

If you take a leave under the Family and Medical Leave Act, you may continue, revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage for these benefits terminates, due to your revocation of the benefit to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference – for example, from \$100 per month to \$150 per month, etc. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

### 04. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage through your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected, ask your Administrator for further details.

### 05. QUALIFIED RESERVIST DISTRIBUTIONS

Notwithstanding any provision of this Plan to the contrary, a Participant may elect to receive a distribution of certain funds from his or her Health Flexible Spending Account if the following criteria is met:

1. The Participant is a Qualified Reservist as defined in the Section titled: "Definitions".
2. The Participant is ordered or called to active duty for a period in excess of 180 days or more, or for an indefinite period. If the period is less than 180 days, a Qualified Reservist Distribution is not allowed unless there are subsequent orders or calls for duty that increase the total period of active duty to 180 days or more.
3. The Participant has provided the Plan Administrator with a copy of the order or call to active duty and;
4. The request for distribution is made during the period beginning with the order or call to duty and ending on the last day of the Plan Year (or Grace Period if applicable) in which the order or call to duty occurred. The Participant delivers a written election to the Plan Administrator in a form designated or requested by the Plan Administrator.

The amount of the QRD shall be any amount not to exceed the entire amount elected for the current Plan Year minus reimbursements received as of the date of the QRD request.

### 06. What happens if my employment terminates?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- a. You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- b. You will still be able to request reimbursement for qualifying dependent care expenses up to 90 days after the date of termination from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.
- c. For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 90 days after the date of termination, claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

**07. Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Company contributions to Social Security on your behalf.



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## VI. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

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### 01. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

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## VII. ARTICLE - PLAN ACCOUNTING

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### 01. Periodic Statements

Periodically during the Plan Year, the Administrator will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

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## VIII. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

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This Section contains certain general information which you may need to know about the Plan.

### 01. **General Plan Information**

Institute on Aging FSA Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The company amends and restates this Plan as of July 01, 2020 with an original effective date of July 01, 2019.

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on July 01 and ends on June 30.

### 02. **Employer Information**

Your Employer's name, address, and tax identification number are:

Institute on Aging  
Kelli Gessner  
3575 Geary Blvd  
San Francisco, CA 94118  
415-750-8747  
kgessner@ioaging.org  
FEIN: 94-2978977

### 03. **Plan Administrator Information**

The name and address of your Plan's Administrator are:

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
415-750-8747  
kgessner@ioaging.org

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

### 04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan. The Plan's Agent of Service is:

Institute on Aging  
3575 Geary Blvd  
San Francisco, CA 94118  
415-750-8747  
kgessner@ioaging.org

### 05. **Type of Administration**

The type of Administration is Employer Administration.

### 06. **Claims Submission**

Claims for expenses should be submitted to:

Accrue CMS  
3633 136th PI SE, Suite 207  
Bellevue, WA 98006

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## IX. ARTICLE - ADDITIONAL PLAN INFORMATION

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### 01. Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- a. examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, 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 (also available at the Public Disclosure Room of the Employee Benefits Security Administration);
- b. obtain copies of all documents that govern the operations of the Plan, and other Plan information, upon written request to the Administrator. The Administrator may charge a reasonable fee for copies;
- c. continue health coverage for yourself, Spouse, or other 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; and
- d. review this summary plan description and the documents governing COBRA continuation rights under the Plan.

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

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 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.

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

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### 02. Claims Process

It is recommended that you submit all reimbursement claims during the Plan Year. For information on how claims will be processed at the end of the Plan Year, please refer to the Article titled: "Benefit Payments".

Claims for insured benefits will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit to the Administrator a written request for reconsideration of the denial.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- a. The specific reason or reasons for the denial;
- b. Reference to the specific Plan provisions on which the denial was based;
- c. 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;
- d. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- e. 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; and
- f. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- a. was relied upon in making the claim determination;
- b. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- d. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

### 03. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

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## **X. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA**

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Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") beyond the time when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

### **01. What is COBRA continuation coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

### **02. Who can become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

- a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

### **03. What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provides that the Plan participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- a. The death of a covered Employee.
- b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- c. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan 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 even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- d. A covered Employee's enrollment in any part of the Medicare program.
- e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**04. What factors should be considered when determining to elect COBRA continuation coverage?**

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should be aware that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**05. What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**06. What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

**07. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- a. the end of employment or reduction of hours of employment,
- b. death of the employee,
- c. commencement of a proceeding in bankruptcy with respect to the Employer, or
- d. entitlement of the employee to any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.**

**NOTICE PROCEDURES:** Any notice that you provide must be *in writing*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Accrue CMS

3633 136th PI SE, Suite 207  
Bellevue, WA 98006

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,

- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**08. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**09. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**11. What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary,



as shown below.

- a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- b. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- c. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- d. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**12. Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

**13. How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

**14. Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

**16. What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**17. Are there other coverage options besides COBRA Continuation Coverage?**

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

coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

18. **Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

19. **How is my participation in the Health Flexible Spending Account affected?**

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$750 and, at the time you terminate employment, you have contributed \$400 but only claimed \$200, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$750. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

## IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. 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 nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

**\*\*HIPAA NOTICE OF PRIVACY PRACTICES\*\***

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

**Purpose**

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

**Uses and Disclosures of Health Information**

**Healthcare Operations.** We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

**Payment.** We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

**Treatment.** Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

**As permitted or required by law.** We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

**Pursuant to your Authorization.** When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

**Right to Inspect and Copy.** In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

**Right to an Accounting of Disclosures.** You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

**Right to Amend.** If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

**Right to Request Restrictions.** You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

**Right to Request Confidential Communications.** You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

**Right to Receive a Paper Copy of this Notice.** If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

**Legal Information**

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below:

Institute on Aging  
Kelli Gessner  
3575 Geary Blvd  
San Francisco, CA 94118  
415-750-8747  
kgessner@ioaging.org

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

**Filing a Complaint**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the

person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for further information.



## Appendix D: Notice of HIPAA Privacy Practices

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

### **Institute on Aging PRIVACY PRACTICES NOTICE**

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

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

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#### **Summary of Our Privacy Practices**

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

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

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

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

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

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

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

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

regarding or additional information about our privacy practices.

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#### Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact

our Contact Office. **{Note: Fax, email and address are optional}**

Contact Office: Contact Human Resources to be referred to the Privacy Officer

Telephone: 415-750-4111

E-mail: HRAdmin@ioaging.com

Address: 3575 Geary Blvd., San Francisco, CA 94118

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#### Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the Health Care Flexible Spending Account

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

Dependent Care Flexible Spending Account

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#### Our Legal Duty

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

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 1999**, and will remain in effect unless we replace it.

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

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#### Uses and Disclosures of Your Medical Information

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

**Payment:** We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you

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



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

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

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

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

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

psychotherapy notes we hold only with your authorization.

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

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

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

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

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

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

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

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

#### **Health-Related Products and Services:**

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

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

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

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

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### **Your Rights**

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

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

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

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

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

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

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

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

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

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

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

operations and is not otherwise required by law; and

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

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

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

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

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

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## Complaints

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

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

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

## Appendix E: Authorized Representatives

### Appointment of Authorized Representative

I, \_\_\_\_\_

[name of claimant]

hereby appoint \_\_\_\_\_ to act on my behalf

[name of Authorized Representative]

or on behalf of \_\_\_\_\_

[name of patient: plan participant or beneficiary]

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

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

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

\_\_\_\_\_

Claimant's signature

\_\_\_\_\_

Date

Accepted: \_\_\_\_\_

Authorized Representative's signature

\_\_\_\_\_

Date

Witness: \_\_\_\_\_

Witness signature

\_\_\_\_\_

Date



## What's Changing for 2022-23?

This memo constitutes a Summary of Material Modifications (SMM) to the Institute on Aging Health and Welfare Benefits Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

**BEGINS Monday, May 16<sup>th</sup> | ENDS Friday, May 27<sup>th</sup>**

### How to Enroll or Waive Benefits for FY23:

1. **Login** to Workday: <https://www.myworkday.com/ioaging/login.html>
2. **Navigate** to your Inbox > Click Open Enrollment Change: Your Name on 07/01/2022
3. **Click** "Let's get started"
4. **Decide** to enroll or waive coverage for each type of benefit. Make sure to enter/review beneficiaries when asked.
5. **Review and Sign** your choices: personal information, dependent information, elections, and total cost.
6. **Submit**: After confirming everything looks right, click submit.

**\*Please see attached more detailed instructions on how to enroll in benefits in Workday**

## What is New this Year?

Below is a summary of enhancements IOA has made to our benefits offerings this year. Please visit our Benefits Portal (link below) for complete information on new plans, existing plans, and additional services being provided to eligible employees and their families beginning July 1, 2022.

Click Here: [IOA Benefits Portal](#)

Employer Key: ioaging

## **New Dependent Cost Share Contribution!**

IOA has continued to hear your concerns around affordability of covering dependents on our medical insurance. Last year we took our first step of contributing \$125 toward the monthly premiums for all dependent coverage levels. This year we focused on continued progress toward the goal of offering market competitive and affordable medical coverage for dependents. We are delighted to share that we have increased our contribution to our **Employees plus Children** coverage level for *all medical plan offerings*. We wanted to better support our working parents, and provide an affordable option, especially to those who may be the sole provider for their children. IOA will be contributing 70% of the total monthly premium cost for the Kaiser and United Health Care base plans, which significantly reduces the employee portion of the monthly premiums for this coverage level! We will continue to contribute \$125 toward the monthly dependent premiums for the Employee plus Spouse/Domestic Partner and Employee plus Family coverage levels.

## **New Additional Holiday!**

Another exciting change is the addition of **Juneteenth** as an **official holiday** at IOA! This increases our paid holiday offerings from *10* to *11*, which still includes a *floating holiday* for you to use to recognize and celebrate any day of the year! Based on your feedback, *The Diversity, Equity, Inclusion, and Belonging Council* has offered some culturally-sensitive suggestions of when you might want to use your floating holiday, and you will see those changes reflected in our updated [IOA Holiday List for 2022](#).

## New UnitedHealthcare PPO Plan Changes

This year there have been mandatory changes to the benefits on the UHC plans. Please see the changes listed out below:

- In-Network Deductible has decreased to \$2,500 per individual and \$5,000 per family
- Out-of-Network Deductible has decreased to \$7,500 per individual and \$15,000 per family
- In-Network Out of Pocket Maximums have increased to \$6,500 per individual and \$13,000 per family
- Out-of-Network Out of Pocket Maximums have increased to \$19,500 per individual and \$39,000 per family
- Virtual Visits are now covered 100%
- Minor Lab Tests and X-rays have increased to 20% coinsurance per visit
- Outpatient Habilitative and Rehabilitative services have decreased to a \$25 copay
- Primary Care Provider visits copay have decreased to a \$25 copay, while Specialist copays have increased to \$50

## Continued Health and Welfare Plan Offerings:

**Kaiser** – Employees can still enroll in IOA's well recognized, lower cost HMO plan.

**UHC** – Employees can still enroll in either of the UHC PPO plans, which offer a more robust network and mental health coverage

**The Difference Card** – All employees enrolled in any of IOA's medical plans should continue to **USE THIS DEBIT CARD**, as **IOA preloads \$2500 a year to help cover out-of-pocket medical expenses** such as copays, coinsurance, and out-of-pocket maximums. For more information on how The Difference Card works, please visit [differencecard.com](https://differencecard.com) or call (888) 343-2110.

**Mental Health Services** – Contact Concern EAP at: [concernhealth.com](https://concernhealth.com) or call (800) 344-4222 to schedule up to **5 counseling sessions**. Employees **also have the choice of accessing Optum's nationwide network of Mental Health providers** through either one of the UHC PPO plans.

**Flexible Spending Accounts** – Set aside additional pre-tax money to help pay for out-of-pocket medical expenses and/or dependent care expenses for children and aging adults of which you care for. Contact Accrue CMS with questions regarding FSAs at: [accruecms.com](https://accruecms.com) or call (866) 517-7580

**Life and Accidental Death & Dismemberment (AD&D) Insurance** – IOA will continue to provide 1 times annual salary up to \$350K maximum of coverage in the event that you have an accident or other catastrophic incident. Offered through Mutual of Omaha!



**Short Term Disability** – IOA paid plan that supplements 60% of earnings up to a maximum of \$1,200 per week.

**Long Term Disability** – IOA paid plan that kicks in after 90 days of STD and supplements 60% of earnings up to a maximum of \$7,500 per week.

**Voluntary Benefits** – Elect additional coverage including Critical Illness and Accident.

## **Need More Information?**

Join us during 1 of 4 virtual benefits fairs to learn more about our new 2022-2023 plans and get an opportunity to ask any questions. United Healthcare will be in attendance during these sessions to help answer any specific questions related to the new PPO plans. A session will also be recorded in case you are unable to make any of these fairs and posted on [IOA's Benefits Portal](#).

## **Virtual Benefits Fairs:**

DATE	TIME	LINK
May 17th	10:00 AM PST	<a href="#">Click here to join the meeting</a>
May 19th	1:00 PM PST	<a href="#">Click here to join the meeting</a>
May 23rd	3:00 PM PST	<a href="#">Click here to join the meeting</a>
May 25th	10:00 AM PST	<a href="#">Click here to join the meeting</a>

## **Questions?**

Please contact The People Team by emailing [HRAdmin@ioaging.org](mailto:HRAdmin@ioaging.org) and include “Open Enrollment” in the subject line. Alternatively, please call (415) 650-0448 press 1 and then 2 to get connected with a Benefits Specialist.

HR Team will be onsite at Geary every day during open enrollment, if you need help enrolling through workday please come by.

In Collaboration,

The IOA People Team

## **ERISA**

Please attach this Summary of Material Modifications to your Summary Plan Description for future reference. Contact the Benefits Department if you have questions regarding the information in this Summary of Material Modification, or if you need another copy of the Summary Plan Description or the Certificate of Insurance Booklets (a copy may also be found on SideBar here). You can request copies of plan materials by contacting the Benefits Department.

## **ERISA Information**

Plan Sponsor: Institute on Aging

EIN: 94-2978977

Plan Name: Institute on Aging Health and Welfare Benefits Plan

Plan Year: 2022-23

Plan Number: 504

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