September 12, 2019

ACTION: **Approve Resolution to Amend, Restate and Adopt Health and Welfare Plan Document and Flexible Benefit Plan Document**

The Board is asked to approve the attached **Board Resolution** that amends, restates and adopts our Health and Welfare Plan Document and the Flexible Benefit Plan Document. The Board established a Health and Welfare Plan in 2001. The Board established the Flexible Benefit Plan in 1987. State statutes give the Board authority to provide employee benefits as noted in Board Policy 2000 and these documents need to be updated in order for the benefit programs to continue.

The Board Resolution contains Exhibits A, B, and C as described below.

Exhibit A
Health and Welfare Plan, Plan Number 501, Plan Document
This document is referred to as the Wrap Plan. This document "wraps" all of our health and welfare benefit plans into one plan document for purposes of administration and application of any applicable legal requirements. It serves as the overarching document for each benefit offering. It is largely governed by the U.S. Department of Labor (DOL) rules.

Exhibit A- Component Plans;
Exhibit B- Eligibility;
Exhibit C- Certificates of Coverage/Booklet; (These are the policies or informational packets for each Component Plan [e.g., medical, dental, vision, wellness] which provide employees with information about each specific benefit.)
Exhibit D- Participating Employers; and,
Exhibit E- Claims Administration.

Exhibit B
Health and Welfare Plan, Plan Number 501, Summary Plan Description
This summary describes the terminology contained in the Wrap Plan. This must be distributed to employees every five (5) years and/or to new hires.

Exhibit A- Claims Procedures;
Exhibit B- Eligibility;
Exhibit C- CHIP Notice; and,
Exhibit D- Attachments- listing all benefits in sub-attachments #1-15.

Exhibit C
Flexible Benefit Plan Document and Summary Plan Description
This document is referred to as the Cafeteria Plan. It allows employees to pay for benefits on a pre-tax basis and is required by the IRS.

Appendix A- List of College and System Office; and,
Appendix B- Exclusions- Medical Expenses that Aren't Reimbursable.

The System Office recommends approval of the Resolution for Health and Welfare Plan and Flexible Benefit Plan Documents.

ATTACHMENTS:

- Board Resolution (PDF)
- Health and Welfare Plan Document Exhibit A (PDF)
- Health and Welfare Plan SPD Exhibit B (PDF)

RESOLUTION
OF THE
BOARD OF TRUSTEES
OF
THE NEBRASKA STATE COLLEGES

September 12, 2019

The undersigned, being all the members of the Board of Trustees of the Nebraska State Colleges (the "Board"), hereby consent to, approve and adopt the following resolutions and each and every action affected thereby.

WHEREAS, the Board established the Nebraska State College System Health and Welfare Plan (the "Health and Welfare Plan") on September 1, 2001;

WHEREAS, the Board established the Nebraska State Colleges Flexible Benefit Plan (the "Flexible Benefit Plan") on October 1, 1987;

WHEREAS, pursuant to the terms of the Plans, the Board of Trustees of the Board has the power and authority to amend and restate the plans at any time;

WHEREAS, the Board of Trustees of the Board now wishes to amend and restate the Plans in their entirety, and adopt the Health and Welfare Plan Document and Flexible Benefit Plan Document;

WHEREAS, other employers wish to confirm participation in both the Health and Welfare Plan and the Flexible Benefit Plan;

WHEREAS, the Health and Welfare Plan and the Flexible Benefit Plan both provide that any other Participating Employer may, with the consent of the Board, adopt the Plan and participate therein upon written approval by the Board; and

WHEREAS, the Board desires that the following employers will be Participating Employers who will adopt both the Health and Welfare Plan and the Flexible Benefit Plan: Chadron State College, Peru State College, Wayne State College, and the Nebraska State College System Office.

NOW THEREFORE, BE IT RESOLVED, that the amended and restated Health and Welfare Plan effective September 1, 2019, attached hereto as Exhibit A, is hereby approved and adopted as of the date set forth below;

RESOLVED FURTHER, that the amended and restated Flexible Benefit Plan effective September 1, 2019, attached hereto as Exhibit C, is hereby approved and adopted as of the date set forth below;

RESOLVED FURTHER, the undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of Health and Welfare Plan as amended and restated, and the accompanying Summary Plan Description approved and adopted in the foregoing resolutions effective as of the date set forth below;

RESOLVED FURTHER, the undersigned further certifies that attached hereto as Exhibit C is a true copy of the Flexible Benefit Plan as amended and restated, approved and adopted in the foregoing resolutions effective as of the date set forth below;

RESOLVED FURTHER, that Chadron State College, Peru State College, Wayne State College, and the Nebraska State College System Office hereby become parties to the Health and Welfare Plan and the Flexible Benefit Plan, and the Board hereby consents to such adoption and participation;

RESOLVED FURTHER, that the members of the Board of Trustees and any officer of the Board be, and each of them individually hereby is, authorized in the name and on behalf of the Board to take or to cause to be taken any and all such further actions as in his or her judgment shall be necessary, desirable, advisable or appropriate to effectuate the purpose and intent of the foregoing resolutions, including, without limitation, executing plan amendments and distributing a summary of material modifications; and

RESOLVED, FURTHER, that any and all prior actions of any of the Board or the officers and agents of the Board in connection with the matters contemplated by the foregoing resolutions are hereby ratified, approved and adopted in all respects.

IN WITNESS WHEREOF, the undersigned members of the Board of Trustees have executed this resolution as of September 12, 2019.

[Name]	[Name]
[Name]	[Name]
[Name]	[Name]
[Name]	

EXHIBIT A

NEBRASKA STATE COLLEGE SYSTEM

HEALTH AND WELFARE PLAN

PLAN NUMBER 501

PLAN DOCUMENT

Originally Effective September 1, 2001

Restated Effective September 1, 2019

EXHIBIT A

THIS DOCUMENT, TOGETHER WITH THE ATTACHED DOCUMENTS LISTED ON THE FINAL PAGE, CONSTITUTES THE WRITTEN PLAN DOCUMENT.

EXHIBIT A

NEBRASKA STATE COLLEGE SYSTEM HEALTH AND WELFARE PLAN

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NEBRASKA STATE COLLEGE SYSTEM HEALTH AND WELFARE PLAN

PLAN DOCUMENT

The Employer originally adopted the Nebraska State College System Health and Welfare Plan effective September 1, 2001. The Plan has been amended many times since its inception. This amendment and restatement is effective September 1, 2019.

ARTICLE I.
INTRODUCTION

1.1 **Purpose of Plan**. The purpose of this Plan is to provide welfare benefits to Participants and Beneficiaries of the Employer with a variety of welfare benefits pursuant to the Component Plans identified in Exhibit A.

1.2 **Plan Document**. This Plan document, together with all Component Plans, constitutes the written document.

EXHIBIT A

ARTICLE II.
DEFINITIONS AND CONSTRUCTION

2.1 **Definitions**. The following definitions shall apply to this document and to the Component Plans. However, in the event of a conflict between a definition below and a definition in a Component Plan, the definition in the Component Plan shall apply to that Component Plan.

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

(b) "**Beneficiary**" means a person designated by a Participant who is or may become entitled to a Benefit under the Plan.

(c) "**Benefits**" means the services provided or amounts paid to or on behalf of Participants and Beneficiaries under the Plan.

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

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

(f) "**Component Plan**" means a component arrangement provided by this Plan, as identified in Section 3.1 and incorporated herein. Component Plans are offered by the Employer and provide an employee benefit. Component Plan also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Component Plan under the Plan is identified in Exhibit A. The Employer may add or delete a Component Plan from the Plan by amending Exhibit A, without any need to otherwise amend the Plan.

In the event that the provisions of any Component Plan conflict with or contradict the provisions of this document or any other Component Plan, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Component Plan.

(g) "**Covered Component**" means each Component Plan that, if it were a separate employee benefit plan, would be a "Covered Entity" within the meaning of HIPAA.

(h) "**Covered Person**" means a Participant or Beneficiary who is enrolled in a Component Plan providing medical, dental, or vision coverage.

(i) "**Dependent**" means a dependent as defined by Code Section 152. A Component Plan may expand or limit the meaning of Dependent.

(j) **"Dependent Care FSA"** means the dependent care assistance program established by the Employer under a separate document. The Dependent Care FSA is a Component Plan under the Plan. It allows Eligible Employees to use pre-tax dollars to pay for many child care-related expenses that are not reimbursed under other programs.

EXHIBIT A

(k) "**Effective Date**" means, for this restatement, September 1, 2019. The original effective date of the Plan was September 1, 2001. The Plan has been amended since then.

(l) "**Eligible Employee**" means an Employee who satisfies the eligibility provisions of Article III and who is not excluded from participation by the terms of an applicable Component Plan.

(m) "**Employee**" means an individual who the Employer classifies and treats as an employee (not as an independent contractor) for payroll purposes, regardless of whether the individual is subsequently reclassified as an employee of the Employer in a court order, in a settlement of an administrative or judicial proceeding, or in a determination by the Internal Revenue Service, the Department of the Treasury, or the Department of Labor.

(n) "**Employer**" means Board of Trustees of the Nebraska State Colleges and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

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

(p) "**FMLA**" means the Family and Medical Leave Act.

(q) "**GINA**" means the Genetic Information Nondiscrimination Act of 2008.

(r) **"Health FSA Plan"** means the health flexible spending arrangement plan established by the Employer under a separate document. The health FSA plan is a Component Plan under the Plan. It allows employees to use pre-tax dollars to pay for most medical, vision, disability, and dental expenses not reimbursed under other programs.

(s) "**HIPAA**" means the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, including the applicable implementing regulations.

(t) "**HITECH**" means the Health Information Technology for Economic and Clinical Health Act.

(u) "**Leave of Absence**" means a personal leave, medical leave or military leave, as approved by the Employer.

(v) "**MHPA**" means the Mental Health Parity Act.

(w) "**MHPEA**" means the Mental Health Parity Addiction Equity Act.

(x) **"Michelle's Law"** means the law that requires group health plans to allow seriously ill or injured college students who are covered Dependents to continue coverage for up to one year while on medically necessary leaves of absence.

EXHIBIT A

(y) "**Military Leave**" means the Employee's absence from employment due to service in the uniformed services as defined by USERRA.

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

(aa) "**Notice of Privacy Practices**" means the notice required for entities covered by HIPAA, pursuant to 45 C.F.R. § 164.520.

(bb) "**Participant**" means an Eligible Employee or the covered eligible Dependent of an Eligible Employee who has chosen to participate in the Plan or a Component Plan and whose participant has not terminated.

(cc) "**Participating Employer**" means any member of the following group including the Employer, if such member adopts the Plan with the Employer's authorization as provided in Section 12.6: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Exhibit D. The Employer shall amend Exhibit D as needed, to reflect a Participating Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Exhibit D may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Trustees.

(dd) "**PHI**" means "protected health information," as that term is defined in HIPAA, but limited to the protected health information created or received by or on behalf of a Covered Component.

(ee) "**Plan**" means this Nebraska State College System Health and Welfare Plan, including all Component Plans, which are hereby incorporated by reference into this Plan document.

(ff) "**Plan Administrator**" means the Educators Health Alliance for medical, dental, and wellness program benefits, or the Employer for all other benefits under the Plan, unless the Employer designates another person to hold the position of Plan Administrator pursuant to Section 8.3.

(gg) "**Plan Sponsor**" means the Educators Health Alliance for medical, dental, and wellness program benefits, or the Employer for all other benefits under the Plan.

(hh) "**Plan Year**" means the fiscal year of the Plan, a twelve (12) consecutive month period beginning every September 1st and ending every August 31st.

(ii) "**Recover**," "**Recovered**," "**Recovery**" or "**Recoveries**" means all moneys paid to the Covered Person to compensate for all losses due to injury or illness resulting from the actions or omissions of a Third Party, whether or

not said losses reflect expenses covered by the Plan. These terms include all moneys paid by way of judgment, settlement, or otherwise. These terms include but are not limited to, moneys for medical, dental, or vision expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other form of damages or compensation whatsoever.

(jj) "**Reimbursement**" means repayment to the Plan for certain benefits that the Plan has paid toward care and treatment of the Covered Person's illness or injury.

(kk) **"Retired Employee"** means a former full-time Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer.

(ll) **"Spouse"** means a spouse as defined under a Component Plan. Notwithstanding anything to the contrary contained therein, the term "Spouse" shall include a same-sex spouse who is legally married under applicable law.

(mm) "**Subrogation**" means the Plan's right to pursue and place a lien upon the Covered Person's claims for certain expenses against a Third Party.

(nn) "**Third Party**" means a person or business entity other than a Covered Person or the Plan, and includes the insurer of such person or business entity.

(oo) "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

(pp) **"WHCRA"** means the Women's Health and Cancer Rights Act of 1998.

2.2 **Construction**. As used in this Plan, the masculine gender includes the feminine, and the singular may include the plural, unless the context clearly indicates to the contrary.

2.3 **Attachments**. Each Component Plan is summarized in an insurance contract, a plan document, or another governing document. When the Plan refers to an insurance contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance booklet). A copy of each contract (including the booklet), plan, or other governing document is attached to this document in Attachments listed in Exhibit C.

2.4 **Non-ERISA Plan**. This document and its Attachments constitute the written plan document. This Plan is a governmental plan not intended to be covered by ERISA.

EXHIBIT A

ARTICLE III.
PARTICIPATION

3.1 **Eligibility for Participation**. An Employee will become a Participant in the Plan when the Employee first becomes a Participant in any Component Plan. An Employee's Dependent becomes a Beneficiary under this Plan when the Dependent first becomes a Beneficiary under any Component Plan. An Employee is eligible to become a Participant in a Component Plan under the terms and conditions described in the Component Plan. Newly eligible Employees must enroll in coverage within 30 days of their effective date of eligibility. If such terms and conditions of eligibility do not appear in the applicable Component Plan, then the eligibility provisions set forth on Exhibit B shall apply.

For purposes of group health plan coverage under the Patient Protection and Affordable Care Act, an eligible Employee is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.

Whether an Employee regularly works 30 or more hours each week shall be determined in accordance with the administrative procedures established by the Plan Administrator which shall be applied in a uniform, nondiscriminatory manner.

Certain Component Plans require an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various Component Plans, is found in the Attachments in Exhibit C. The Plan Administrator shall establish procedures for enrollment of Eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.2 **Cessation of Participation**. Participation in this Plan ceases when an individual is no longer eligible for participation and enrolled in any Component Plan.

3.3 **Reinstatement of Participation**. If an individual's participation in a Component Plan ceases as set forth in Section 3.2, such participation may be reinstated upon the individual's satisfaction of the requirements contained in Section 3.1. Such participation may be reinstated earlier pursuant to the terms of an applicable Component Plan.

EXHIBIT A

ARTICLE IV.
BENEFITS

4.1 **Benefits**. The Benefits under this Plan shall be provided to each Participant and Beneficiary as described in the applicable Component Plan. The Plan also provides employees with the opportunity to participate in a Cafeteria Plan. A summary of each benefit provided under the Plan is set forth in the attached insurance contract (including the certificate of insurance), plan document, or other governing documents and listed in Exhibit C.

4.2 **Termination of Benefits**. Except as otherwise provided in any applicable Component Plan, Benefits under any Component Plan will terminate upon the earliest of the following:

(a) The Participant elects to drop coverage during an annual enrollment period or during any other period when such a change is permitted under the applicable Component Plan.

(b) The Participant fails to make the required contribution.

(c) The Participant or Beneficiary, as applicable, ceases to be eligible for Benefits under the terms of the applicable Component Plan.

(d) A Component Plan (or an option under a Component Plan) is terminated in accordance with Article X.

4.3 **Right to Recover Benefit Overpayments and Other Erroneous Payments**. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant or a Beneficiary, the Participant or the Beneficiary shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, the Plan Administrator or the Employer (or designee) may recover that incorrect payment, whether or not it was made due to the insurance companies' 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, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of 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 companies. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

With respect to Component Plans provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured Component Plans, subrogation or reimbursement rights may be set forth in the plan document or other governing documentation.

4.4 **Participant's Responsibilities**. Each Participant shall be responsible for providing the Plan Administrator and the Employer and, if required by an insurance company, with respect to a fully-insured benefit, the insurance company with his or her current address. If required by the insurance company, with respect to a fully-insured benefit, each employee who is a Participant

shall be responsible for providing the insurance company with the address of each of his or her covered eligible Dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The insurance companies, the Plan Administrator and the Employer shall have no obligation or duty to locate a Participant.

4.5 **Right to Information and Fraudulent Claims**. Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully-insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully-insured benefit, the insurance company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and so often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully-insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Participant related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

EXHIBIT A

ARTICLE V.
CONTINUATION COVERAGE

5.1 **USERRA**. If an Employee is covered under a Component Plan and takes a Military Leave lasting 31 days or less, the Employee will continue to be covered by the applicable Component Plan as a regular, active Employee. If an Employee is covered under a Component Plan and takes a Military Leave of more than 31 days, the Employee will be deemed to be on an approved unpaid leave of absence while on Military Leave, and will be covered by the Component Plan (including with regard to reinstatement) to the same extent as any employee on another approved unpaid leave of absence. Any Component Plan that is a "health plan" within the meaning of USERRA will offer continuation coverage to an Employee (and any eligible Dependents) while the Employee is on Military Leave, to the extent required by USERRA. Any continuation coverage provided pursuant to this paragraph will be concurrent with any COBRA continuation coverage elected by the Employee or Dependent, as applicable.

5.2 **FMLA**. If an Employee takes FMLA leave, coverage under a Component Plan that is a "group health plan" within the meaning of the FMLA will be continued under the same terms and conditions as for active Employees, unless the Employee elects to not continue the coverage during leave. If coverage continues during FMLA leave, the Employee must continue to pay any contributions which the Employee was required to pay on the day immediately prior to the FMLA Leave, except that the Employee's cost may be increased or decreased in the same manner and to the same extent as for active Employees.

5.3 **COBRA**. A Component Plan that is a "group health plan" within the meaning of COBRA shall offer continuation coverage to the extent required by COBRA.

5.4 **State Continuation Rights**. Each Component Plan shall provide continuation rights to the extent required by applicable state law that is not otherwise preempted.

EXHIBIT A

ARTICLE VI.
HIPAA PRIVACY AND SECURITY

6.1 **Applicability**. This Plan is a "hybrid entity" within the meaning of HIPAA. This Plan elects to provide the privacy and security protections required by HIPAA only to the Covered Components.

6.2 **Uses and Disclosures of PHI by Employer**. The Employer may use or disclose PHI pursuant to this Section, which may be further limited by the Employer's HIPAA policies and procedures.

(a) **Permitted Uses and Disclosures**. The Employer may use and disclose any PHI obtained pursuant to this Article only for the purposes of administrative functions that the Employer performs for or on behalf of a Covered Component.

(b) **Required Uses and Disclosures**. The Employer is required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 C.F.R. § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 C.F.R. § 164.528 in order to provide an individual with an accounting of disclosures of that individual's PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with HIPAA.

6.3 **Restrictions on Employer's Use and Disclosure of PHI**.

(a) The Employer will not use or disclose Participants' PHI, except: (i) as required by law; or (ii) as permitted or required by this Plan Document (which may be further limited by the provisions of a Covered Component or by the Employer's HIPAA policies and procedures).

(b) The Employer will ensure that any agent, including any subcontractor, to whom it provides Participants' PHI, agrees to the restrictions and conditions of this Article with respect to Participants' PHI.

(c) The Employer will not use or disclose Participants' PHI: (i) for the purpose of employment related actions or decisions; (ii) in connection with a non-Covered Component; or (iii) in connection with any other employee benefit of the Employer.

(d) Promptly upon learning of any use or disclosure of Participants' PHI that is inconsistent with the uses and disclosures allowed under this Article, the Employer will report such inconsistent use or disclosure to the applicable Covered Component.

(e) The Employer will make PHI available to the Participant who is the subject of the information, in accordance with 45 C.F.R. § 164.524.

(f) The Employer will make Participants' PHI available for amendment, and will amend Participants' PHI, in accordance with 45 C.F.R. § 164.526.

(g) The Employer will make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) The Employer will make its internal practices, books and records (as they relate to its use and disclosure of Participants' PHI) available to the U.S. Department of Health and Human Services for the purpose of determining compliance with 45 C.F.R. Parts 160 64.

(i) If feasible, the Employer will return or destroy all Participants' PHI that the Employer 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, Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6.4 **Adequate Separation Between Employer and the Plan**. The following members of the Employer's workforce may be given access to Participants' PHI by Employer: General Counsel and Vice Chancellor for Employee Relations; HR Specialist; Human Resources Directors; Payroll Managers; and Human Resources Coordinators. These individuals will have access to Participants' PHI only to perform the administrative functions that the Employer conducts for the Covered Components. These individuals will be subject to disciplinary action and sanctions, including termination of employment, for any use or disclosure of Participants' PHI in violation of the provisions of this Article, of HIPAA, or of the Employer's HIPAA policies and procedures. The Employer will promptly report any such violation to the Covered Component, and will cooperate with the Covered Component in order to correct the violation; impose appropriate disciplinary action or sanctions on each person causing the violation, and mitigate any negative effect of the violation on any Participant, the privacy of whose PHI may have been compromised by the violation.

6.5 **Disclosure to Employer**. Any use or disclosure of PHI to the Employer pursuant to this Section must be in accordance with the policies and procedures of the Covered Component and of the Employer.

(a) For the purpose of conducting administrative functions on behalf of a Covered Component, which functions must be consistent with HIPAA and the applicable Notice of Privacy Practices, the Employer shall be entitled to receive PHI from: (i) a Covered Component; (ii) any business associate of a Covered Component; (iii) any person or entity that contracts with such business associate; (iv) any person or entity that contracts with the Employer to provide services to or on behalf of the Covered Component; (v) any health insurer or health insurance issuer or HMO that provides health benefits coverage or services to or on behalf of the Covered Component; (vi) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Participants; and (vii) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Participant.

(b) Notwithstanding the foregoing, PHI shall not be disclosed to the Employer: (i) for the purpose of employment related actions or decisions; (ii) in

connection with a non-Covered Component; or (iii) in connection with any other employee benefit of the Employer that is not offered under this Plan.

(c) A Covered Component may disclose PHI to the Employer if the PHI summarizes the claims history, claims expenses, or types of claims experienced by individuals under the Covered Component, provided that the information described in 45 C.F.R. § 164.514(b)(2)(i) has been deleted (except that geographic information need only be aggregated to the level of a 5-digit zip code).

(d) A Covered Component may disclose to the Employer information on whether an individual is participating in a Covered Component or is enrolled or has disenrolled from a particular coverage options within a Covered Component.

6.6 **Minimum Necessary**. The Employer will make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, the Employer will make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.

6.7 **Employer's Certification of Compliance**. Neither a Covered Component nor any health insurance issuer or business associate providing services to a Covered Component will disclose Participants' PHI to the Employer unless the Employer certifies that this Plan includes the terms of this Article and that the Employer agrees to abide by this Article.

6.8 **Security Provisions**. The Employer will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of a Covered Component;

(b) Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Covered Component any security incident of which it becomes aware.

EXHIBIT A

ARTICLE VII.
REIMBURSEMENT/SUBROGATION

7.1 **Applicability**. In the event of a conflict between the provisions of this Article and the provisions of a Component Plan, whichever provisions provide the greatest rights to this Plan and/or the Component Plan shall govern.

7.2 **Obligations of the Covered Person**.

(a) **No Prejudicial Acts**. A Covered Person shall take no action to prejudice the rights of the Component Plan.

(b) **Notice**. A Covered Person must notify the Plan Administrator immediately of any potential causes of action or claims for a Recovery that the Covered Person may have against a Third Party. A Covered Person must provide the Plan Administrator with a copy of any summons, complaint, or other process serviced in any lawsuit in which the Covered Person seeks a Recovery. A Covered Person must notify the Plan Administrator immediately of any settlement offer regarding a potential Recovery.

(c) **Cooperation**. A Covered Person must cooperate and assist the Component Plan in enforcing its Subrogation and Reimbursement rights. Upon request, the Covered Person must: (i) provide details of the illness or injury; (ii) authorize the release of information, including the names of all providers from whom the Covered Person received service or treatment; (iii) provide information about other insurance coverage and benefits; (iv) provide such other information as may be requested by the Component Plan; (v) assist the Component Plan in any action against the Third Party; and (vi) execute a Subrogation Agreement, Assignment of Recoveries, and Reimbursement Agreement in favor of the Component Plan.

(d) **Reimbursement**. In the event that a Recovery is paid from a Third Party directly to the Covered Person, the Covered Person must reimburse the Component Plan the amount of any payments previously made to the Covered Person by the Component Plan (or for which the Component Plan may have future responsibility) with respect to that illness or injury.

(e) **Trust**. The Covered Person must hold any Recovery (including amounts paid for future medical expenses) and any right of Recovery against the Third Party in trust for the Component Plan.

(f) **Settlement**. The Covered Person must obtain written consent from the Plan Administrator before entering into any settlement agreement with a Third Party.

7.3 **Rights of the Component Plan**.

(a) **Subrogation**. The Component Plan may take action against any party (including, but not limited to, an attorney or trust) in possession of property or funds awarded or paid as a result of the Covered Person's illness or injury, if such property or funds should be or should have been paid to the

Component Plan under this Article. The Component Plan has the right to seek a temporary restraining order against such party to prevent disbursement of such property or funds. In addition, the Component Plan may seek restitution in equity (through the imposition of a constructive trust for the Plan's benefit) from such party for the full amount of benefits paid by the Component Plan or for which it may have future responsibility.

(b) **Reimbursement**. The Component Plan shall legally succeed the Covered Person's right of Recovery against a Third Party, up to the amount of benefits it has paid (or for which the Component Plan may have future responsibility) with respect to that illness or injury. The Component Plan shall have first priority on any money Recovered from the Third Party, including any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, homeowner's or renter's coverage, medical malpractice or any liability plan. The Component Plan's contractual right to Reimbursement is in addition to and separate from equitable Subrogation, and may be enforced under the same terms as discussed in this Section.

(c) **Fees and Costs**. If the Component Plan files suit in order to enforce its right to Recover from the Covered Person, the Component Plan reserves the right to be reimbursed for its court costs and attorneys' fees in relation to such suit.

7.4 **Settlement Agreements/Judgment Awards**. The Covered Person must obtain written consent from the Plan Administrator before entering into any settlement agreement with a Third Party. If a settlement agreement or a judgment award includes payment for future medical expenses, a trust account may be established by the Plan Administrator or the Component Plan. In the absence of such a trust, the Component Plan has the right to exclude coverage for the Covered Person's future medical expenses, related to the illness or injury, up to the full amount of the settlement or award.

7.5 **Priority; Other Legal Doctrines**. If the Third Party makes any payment to the Covered Person, his or her attorney, or an trust for his or her benefit, such payment must first be used to provide equitable restitution to the Component Plan, to the full extent of benefits paid by or payable under the Plan. This priority of the Component Plan applies despite other legal doctrines or theories. The Component Plan's rights of Subrogation and Reimbursement under this Article shall not be affected, reduced, or eliminated by the make-whole doctrine, the common fund doctrine, the doctrine of comparative fault theory, or any other legal doctrine or theory. Each Component Plan expressly rejects the common fund doctrine with regard to attorneys' fees. The rights of the Component Plan shall not be affected, reduced, or eliminated by any allocation which purports to allocation Recovery amounts in whole or in part to nonmedical damages.

7.6 **Conditions Precedent**.

(a) **Cooperation**. If a Covered Person refuses to comply with its obligations under this Article, fails to cooperate with the Component Plan in regard to Subrogation and Reimbursement rights, or refuses to execute and deliver such papers as the Component Plan may require in furtherance of its Subrogation and Reimbursement rights, then the Component Plan shall have no obligation to pay benefits to the Covered Person.

(b) **Minors**. If the Covered Person is a minor, the Component Plan shall have no obligation to pay benefits related to the illness or injury caused by a Third Party until after the Covered Person's legal representative obtains valid court recognition and approval of the Component Plan's 100%, first-dollar Subrogation and Reimbursement rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement of such rights.

7.7 **Right to Offset Benefits**. If a Covered Person fails to reimburse the Component Plan as provided in this Article, the Component Plan may offset any future benefits otherwise payable to the Covered Person or any member of the Covered Person's family unit, until the amount required to be reimbursed under this Article is fully offset.

7.8 **Termination of Coverage**. If a Covered Person fails or refuses to comply with this Article, the Component Plan may terminate the Covered Person's coverage.

7.9 **Rights of Plan Administrator**. The Plan Administrator has a right to request reports on all settlements. The Plan Administrator has full discretionary authority to approve all settlements.

EXHIBIT A

ARTICLE VIII.
ADMINISTRATION OF PLAN

8.1 **Funding**. The Benefits under a Component Plan may be funded by an insurance policy, by the Employer's general assets, by Employee contributions, or by some combination of these. Contributions are established by the Employer. The Employer reserves the right to modify the cost sharing of contributions between the Employer and Participants, in such amounts as the Employer in its absolute discretion shall determine from time-to-time.

8.2 **Limitation of Rights**. Nothing in this document requires the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant. 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. Nothing in this Plan shall give any Employee any right to continued employment.

8.3 **Power of Appointment**. The Employer has the power to appoint the Named Fiduciary and the Plan Administrator.

8.4 **Plan Administrator**. The Plan Administrator is the Named Fiduciary of the Plan. The Employer may appoint either an individual or a committee to serve as the Plan Administrator on its behalf. An individual appointed by the Employer may resign by providing written notice to the Employer. A committee appointed by the Employer may act by a majority of its members at the time in office, either by vote at a meeting or in writing without a meeting. Such a committee may authorize any one or more of its members to execute any document or documents on behalf of the Plan Administrator.

8.5 **Powers and Duties of the Plan Administrator**. Except as otherwise provided in or delegated by any applicable Component Plan, the Plan Administrator shall have full power to administer the Plan, in accordance with its terms, for the exclusive benefit of Participants and Beneficiaries. For this purpose, the Plan Administrator's full and discretionary powers include, but are not limited to, the following:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable law;

(b) To consider and decide claims and appeals filed under the Plan and any Component Plan;

(c) To determine the eligibility, participation, status, and rights of all individuals under the Plan and any Component Plan;

(d) To construe or interpret any and all terms of the Plan and any Component Plan;

(e) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

(f) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing.

All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

8.6 **Governing Law**. This Plan is established in the State of Nebraska. To the extent federal law does not apply, this Plan shall be construed in accordance with and governed by the laws of the State of Nebraska.

8.7 **Alienation**. No Benefits under this Plan may be subject to anticipation, garnishment, attachment, execution or levy of any kind, or be liable for any Participant's or Beneficiary's debts or obligations.

8.8 **Indemnification of Plan Administrator**. The Employer agrees to indemnify and to defend, to the fullest extent permitted by law, any member (or former member) of a committee appointed by the Employer to serve as the Plan Administrator, or any Employee (or former Employee) appointed by the Employer to serve as the Plan Administrator, against all liabilities, damages, costs and expenses (including attorneys' 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.

8.9 **Power and Authority of Insurance Company**. Certain benefits under the Plan are fully insured. For those benefits that are fully insured, the insurance companies are responsible for: (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

The insurance companies, not the Employer, are responsible for paying claims with respect to these programs. The Employer shares responsibility with the insurance companies for administering these program benefits.

Insurance premiums for employees and their eligible family members are paid in part by the Employer out of its general assets and in part by employees' pre-tax payroll deductions through the Cafeteria Plan. The Plan Administrator provides a schedule of the applicable premiums on request for each of the Component Plans, as applicable.

8.10 **Plan Expenses**. The costs and expenses incurred in the administration of the Plan and the Component Plans shall be paid, in the discretion of the Administrator: (i) from assets accumulated under the Plan and the Component Plans, if any; (ii) from Employee contributions; or (iii) by the Employers in such proportion as the Company or the Administrator shall determine.

EXHIBIT A

ARTICLE IX.
CLAIMS PROCEDURES

9.1 **Applicability**. In the event that a Component Plan lacks a claims procedure, this Article shall apply to such Component Plan. Exhibit E contains contact information for questions relating to Claims.

9.2 **Definitions**. For purposes of this Article:

(a) "**Claim**" means a Disability Claim, a Medical Claim, or a Standard Claim.

(b) "**Claimant**" means any person who submits a Claim, including any authorized representative who submits a Claim on another's behalf.

(c) "**Disability Claim**" means a written request for a disability benefit under this Plan or a Component Plan.

(d) "**Medical Claim**" means a written request for medical, dental, vision, or EAP benefits, or for reimbursement of other health care expenses, under this Plan or a Component Plan. There are three types of Medical Claims:

(i) "**Pre-Service Claim**" means a Medical Claim, if receipt of the benefit is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(ii) "**Post-Service Claim**" means any Medical Claim other than an Urgent Care Claim or a Pre-Service Claim.

(iii) "**Urgent Care Claim**" means any Medical Claim with respect to which medical care decisions, if made on a non-urgent time frame: (i) could seriously jeopardize the life or health of the Claimant; (ii) could seriously jeopardize the Claimant's ability to regain maximum function; or (iii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

(e) "**Rescission**" means the cancellation or discontinuation of coverage that is applied retroactively to coverage.

(f) "**Standard Claim**" means a written request for benefits under this Plan or a Component Plan, other than a Disability Claim or a Medical Claim.

9.3 **Initial Claim**.

(a) **Submitting an Initial Claim**. In order to receive benefits under a Component Plan, a Claimant must submit a Claim to the Plan Administrator.

(b) **Timing of Initial Claim**. Claims must be filed no later than one year after the date on which the applicable service was rendered or after the applicable event occurred. Any claim filed after the expiration of the one year period

shall be barred and the Claimant shall be ineligible for benefits under the Plan.

(c) Claimant's Failure to Follow Procedures.

(i) Pre-Service Claims. If a Claimant fails to follow the procedures for filing a Pre Service Claim (including an Urgent Care Claim), the Plan Administrator will notify the Claimant of the failure and of the proper procedures to be followed. The notice will be given as soon as possible, but not later than five (5) days following receipt of the failed claim (72 hours if the failed claim is an Urgent Care Claim). The notification may be oral, unless the Claimant requests written notification. Such a notification is required only if the failed Claim: (A) is received by a person or organizational unit customarily responsible for handling benefit matters; (B) names a specific Claimant, names a specific medical condition or symptom, and names a specific treatment, service or product for which approval is requested.

(ii) Other. Any other Claimant failure to follow the claims procedures shall be treated as if the Claim had not been filed. The Plan Administrator shall have no obligation to notify the Claimant of such failures.

(d) Approval of Initial Claim. If a Claim is approved, the Plan Administrator will provide the Claimant with written or electronic notice of such approval. The notice will include:

(i) The amount of benefits to which the Claimant is entitled;

(ii) The duration of such benefit;

(iii) The time the benefit is to commence; and

(iv) Other pertinent information concerning the benefit.

(e) Notice of Denial of Initial Claim or Rescission. If a Claim is denied (in whole or in part) or in the event of a Rescission of coverage, the Plan Administrator will provide the Claimant with written or electronic notification of such denial. The notice of denial of the Claim will include:

(i) The specific reason that the Claim was denied;

(ii) A reference to the specific provisions of the Plan on which the denial was based;

(iii) A description of any additional material or information necessary to perfect the Claim and an explanation of why this material or information is necessary;

(iv) A description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action if the Claim is denied on appeal;

(v) If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding a Medical Claim or Disability Claim, either: (A) the specific rule, guideline, protocol, or other similar criterion; or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

(vi) If the denial of a Medical Claim or Disability Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; or (B) a statement that such explanation will be provided free of charge upon request; and

(vii) If the denial is of an Urgent Care Claim, a description of the expedited appeals procedures.

(viii) If the denial is of a Disability Claim, a discussion of the decision that includes the basis for disagreeing with or not following: (A) the views, presented by the Claimant to the plan, of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (B) the views of medical or vocational experts whose advice was obtained on the plan's behalf in connection with a Claimant's benefit denial, regardless of whether the advice was relied on in making the benefit denial; and (C) a disability determination made by the Social Security Administration regarding the claimant, if presented to the plan; and

(ix) If the denial is of a Disability Claim, a statement informing the Claimant of his or her right to receive, upon request and free of charge, reasonable access to and copies of the entire claim file and other relevant documents.

(f) **Timing of Claims Decision**. The notice required by this Section will be provided within the following time frames, unless special circumstances require an extension of time for processing the Claim.

(i) For a Standard Claim, no more than 90 days after receipt of the Claim by the Plan Administrator.

(ii) For a Disability Claim, no more than 45 days after receipt of the Claim by the Plan Administrator.

(iii) For a Post Service Claim, no more than 30 days after receipt of the Claim by the Plan Administrator.

(iv) For a Pre Service Claim, no more than 15 days after receipt of the Claim by the Plan Administrator.

(v) For an Urgent Care Claim, no more than 72 hours after receipt of the Claim by the Plan Administrator. Notice of a decision on an Urgent Care Claim may be provided orally within this time frame, provided that written or electronic notice is provided no less than 3 days after the oral notification. If the Claimant fails to provide sufficient information for the Plan Administrator to decide an Urgent Care Claim, the Plan Administrator will notify the Claimant of the specific information necessary to complete the Claim as soon as possible, but no later than 24 hours after receipt of the Claim. The Plan Administrator will allow additional time for the Claimant to provide the specified information. The additional time will be a reasonable amount of time, taking into account the circumstances, but not less than 48 hours. In such cases, the Plan Administrator will notify the Claimant of its benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the receipt of the specified additional information; or (2) the expiration of the period afforded the Claimant to provide the specified additional information.

(g) **Concurrent Care Decisions**. If the Plan Administrator has previously approved a Medical Claim for an ongoing course of treatment to be provided over a period of time or numbers of treatments:

(i) Any decision reducing or terminating the course of treatment (other than by amendment or termination of this Plan or the applicable Component Plan) before the end of an approved period of time or number of treatments shall constitute a Claim denial. The Plan Administrator shall provide the Claimant with a notice denying the Claim sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal decision before the benefit is reduced or terminated.

(ii) If an Urgent Care Claim seeks to extend the course of treatment beyond the period of time or number of treatments previously approved, the Plan Administrator will decide the Claim as soon as possible, taking into account the medical exigencies. If such a Claim is made at least 24 hours prior to the expiration of the approved period of time or number of treatments, the Plan Administrator will decide the Claim and notify the Claimant of the decision (no matter whether the Claim is granted or denied) within 24 hours after receipt of the Claim.

(iii) The Plan will continue to provide coverage pending the outcome of an Appeal.

9.4 **Appeals**.

(a) **Filing an Appeal**. In the event that a Claim is denied (in whole or in part), the Claimant may appeal the denial by providing a written notice of appeal

to the Plan Administrator within 180 days after the Claimant receives the notice of denial of the Claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the Claim. The Claimant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial Claim.

(b) General Appeal Procedure. The Plan Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal:

(i) No deference will be given to the decision denying the initial Claim.

(ii) The appeal will be decided by an individual who did not decide the initial Claim and who is not a subordinate of anyone who decided the initial Claim.

(iii) The individual deciding the appeal will review and consider all information submitted by the Claimant, without regard to whether the information was submitted or considered in conjunction with the initial Claim.

(iv) If the appeal is based, in whole or in part, on a medical judgment, the individual deciding the appeal will consult with a health care professional who has appropriate training and experience in the relevant field; the health care professional will not be an individual who participated in the denial of the initial Claim and will not be the subordinate of any such individual.

(v) If the Plan Administrator obtained advice from any medical or vocational experts in conjunction with the initial Claim, such experts will be identified to the Claimant (this identification must occur even if the Plan Administrator did not rely on the advice obtained).

(vi) If the Plan obtains new or additional evidence that it intends to consider or rely upon in making its determination, the Plan will provide the new information or evidence to the Claimant as soon as possible and will give the Claimant a reasonable opportunity to respond.

(c) Special Appeal Procedure for Urgent Care Claims. In addition to the procedures set forth in the preceding section, the following will apply to the appeal of an Urgent Care Claim:

(i) A request for expedited review must be made to the Plan Administrator, but may be made either orally or in writing.

(ii) All necessary information will be transmitted from the Plan Administrator to the Claimant by telephone, facsimile, or similarly expeditious means.

(iii) The Claimant may also consider a request for an expedited External Review as discussed below.

(d) **Special Appeal Procedure for Disability Claims.** In order to ensure full and fair review, the following procedures must be followed for Disability Claims:

(i) Before the plan can issue an appeal decision on a Disability Claim, the Plan Administrator must provide the Claimant, free of charge, with any new or additional evidence considered, relied on, or generated by the plan, insurer, or other person making the benefit determination regarding the claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the appeal decision must be furnished so that the Claimant has a reasonable opportunity to respond before that date.

(ii) Before the plan can issue an appeal decision on a Disability Claim based on a new or additional rationale, the Plan Administrator must provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which appeal decision must be furnished so that the Claimant has a reasonable opportunity to respond before that date.

(e) **Notice of Decision on Appeal**. The appeal decision will be provided in written or electronic form to the Claimant. If the appeal decision is adverse to the Claimant, the written decision will include the following:

(i) The specific reason or reasons for the appeal decision;

(ii) Reference to the specific provisions of the Plan on which the appeal decision is based;

(iii) 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.

(iv) A statement describing any voluntary appeal procedures and the Claimant's right to obtain the information about such procedures;

(v) A statement of the Claimant's right to bring an action;

(vi) If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding a Medical Claim or Disability Claim, either: (A) the specific rule, guideline, protocol, or other similar criterion; or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

(vii) If the denial of a Medical Claim or Disability Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either: (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the

Claimant's medical circumstances; or (B) a statement that such explanation will be provided free of charge upon request; and

(viii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(ix) If the claim is a Disability Claim, a statement of the Claimant's right to sue, including a description of any applicable contractual limitations period applicable to the Claimant's right to bring the action, including the calendar date on which the contractual limitations period expires for the Disability Claim.

(x) If the denial is of a Disability Claim, a discussion of the decision that includes the basis for disagreeing with or not following: (A) the views, presented by the Claimant to the plan, of health care professionals treating the Claimant and vocational professionals who evaluated the claimant; (B) the views of medical or vocational experts whose advice was obtained on the plan's behalf in connection with a Claimant's benefit denial, regardless of whether the advice was relied on in making the benefit denial; and (C) a disability determination made by the Social Security Administration regarding the claimant, if presented to the plan.

(f) Timing of Notice of Decision on Appeal. The Plan Administrator will render a decision on appeal within the following time frames, unless special circumstances require an extension of time.

(i) For a Standard Claim, no more than 60 days after receipt of the appeal by the Plan Administrator.

(ii) For a Disability Claim, no more than 45 days after receipt of the appeal by the Plan Administrator.

(iii) For a Post Service Claim, no more than 60 days after receipt of the appeal by the Plan Administrator.

(iv) For a Pre Service Claim, no more than 30 days after receipt of the appeal by the Plan Administrator.

(v) For an Urgent Care Claim, no more than 72 hours after receipt of the appeal by the Plan Administrator.

9.5 Extensions of Time.

(a) Notice of Extension. If the Plan Administrator requires an extension of time to review a Claim or an appeal, the Plan Administrator will provide the

Claimant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include:

(i) An explanation of the circumstances requiring the extension, which circumstances must be matters beyond the control of the Plan Administrator;

(ii) The date by which the Plan Administrator expects to render a decision;

(iii) The standard on which the Claimant's entitlement to a benefit is based; and

(iv) The unresolved issues, if any, that prevent a decision on the Claim or on appeal and the information, needed to resolve those issues. In the event such information is needed, the Claimant will have at least 45 days in which to provide the specified information. In addition, the time for determining an initial Claim will be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

(b) **Extensions for Initial Claims**. The Plan Administrator's ability to extend the time for deciding an initial Claim is subject to the following limitations:

(i) For a Standard Claim, no more than one extension of 90 days.

(ii) For a Disability Claim, no more than two extensions of 30 days.

(iii) For a Post Service Claim, no more than one extension of 15 days.

(iv) For a Pre Service Claim, no more than one extension of 15 days.

(v) For an Urgent Care Claim, no extensions allowed.

(c) **Extension for Appeals**. The Plan Administrator's ability to extend the time for deciding an appeal is subject to the following limitations:

(i) For an appeal of a Standard Claim, no more than one extension of 60 days.

(ii) For an appeal of a Disability Claim, no more than one extension of 45 days.

(iii) For an appeal of a Medical Claim, no extensions allowed.

9.6 **External Review**.

(a) **Requesting and External Review**. In the event that an Internal Appeal results in a denial based upon medical judgment or a Rescission (in whole or in part), the Claimant may request an External Review by giving written

notice of the appeal to the Plan Administrator within 120 days after the Claimant receives the notice of decision on the Internal Appeal.

(b) **Eligibility for External Review**. Within 5 business days following the date of receipt of the External Review request, the Plan Administrator will complete a preliminary review of the request to determine whether the matter is eligible for External Review. A matter is eligible for External Review only if it meets all of the following requirements:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested;

(ii) The denial does not relate to the Claimant's failure to meet the eligibility requirements under the terms of the Plan (in other words, the External Review process does not apply to eligibility determinations);

(iii) The Claimant has exhausted the Plan's internal appeal process; and

(iv) The Claimant has provided all the information required to process an External Review.

(c) **Notice of External Review Eligibility**. Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. The notification will advise Claimant that:

(i) The claim is not eligible for External Review;

(ii) The claim is eligible and ready for External Review; or

(iii) It is unclear whether the claim is eligible for External Review because Claimant has not provided all the information required.

(d) **External Review Process**. If the claim is eligible and ready for External Review, the Plan Administrator will assign an Independent Review Organization ("IRO") that is accredited by URAC (a nonprofit organization promoting healthcare quality by accrediting healthcare organizations) or by a similar nationally recognized accrediting organization to conduct the external review.

(i) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review, including a statement that the Claimant may submit in writing, within 10 business days, additional information which the IRO must then consider when conducting the External Review; and

(ii) Within 5 business days after the date of assignment to the IRO, the Plan Administrator will provide the IRO the documents and any information considered in deciding the Initial Claim and the Internal Appeal.

(iii) Within 45 days after it receives the request for External Review, the IRO will deliver a notice of decision to Claimant.

(iv) The IRO's decision shall be binding on all parties unless and until there is a judicial decision otherwise.

(e) **Eligibility for Expedited External Review**. Claimant may request an "expedited" External Review in the following circumstances:

(i) Claimant: (a) has received a decision on an initial claim involving either urgent care or concurrent care; (b) has filed a request for an Appeal; and (c) has a medical condition for which the timeframe for completion of an Appeal would seriously jeopardize Claimant's life or health or would jeopardize Claimant's ability to regain maximum function.

(ii) Claimant: (a) has completed an Internal Appeal; and (b) has a medical condition for which the timeframe a standard External Review would seriously jeopardize Claimant's life or health, would jeopardize Claimant's ability to regain maximum function.

(iii) (a) Claimant has completed an Internal Appeal; (b) the Appeal concerns an admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services; and (c) Claimant has not been discharged from the facility.

(f) **Expedited External Review Process**.

(i) A request for an expedited External Review must be accompanied by a written statement from Claimant's physician that Claimant's medical condition meets the criteria above.

(ii) The IRO will provide notice of its decision on an expedited External Review as expeditiously as Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO's receipt of Claimant's request. If the notice is not in writing, the IRO will provide written notice to Claimant within 48 hours after its decision.

9.7 **Legal Action**. A Claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a Claim. Further, any legal action with respect to a denial of benefits must be filed within three years of the date of the final denial of a Claim.

EXHIBIT A

ARTICLE X.
AMENDMENT AND TERMINATION

10.1 **Amendment**. This Plan may be amended at any time and from time-to-time by a written instrument approved by the Employer and executed by a duly authorized officer of the Employer. For this purpose, amending the Plan includes making changes to a Component Plan. Terminating a Component Plan (including terminating an insurance contract through which such benefits are provided) is not termination of the Plan. Rather, it is an amendment to the Plan.

Notwithstanding the foregoing, Exhibit A describing Component Plans and Exhibit C describing Certificates of Coverage/Booklets may be updated periodically to reflect the current Component Plans and Certificates of Coverage/Booklets without the need for a formal Plan amendment to the extent the updated Exhibits do not alter the existing terms of the Plan.

The Vice Chancellor for Employee Relations of the Employer may sign insurance contracts for this Plan on behalf of the Employer, including amendments to those contracts, and may adopt (by written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

10.2 **Termination**. This Plan is established with the intention of being maintained for an indefinite period of time. Nevertheless, the Employer expressly reserves the right to discontinue or terminate this Plan or any Component Plan. After the Employer has discontinued or terminated the Plan, no Employee, Dependent or Beneficiary shall have or attain any vested right, contractual or otherwise, to any further contributions to or benefits from the Plan.

EXHIBIT A

ARTICLE XI.
MISCELLANEOUS

11.1 **Employment Not Guaranteed**. The Employer may terminate the employment of any Employee as freely and with the same effect as if this Plan and any Component Plans were not in existence. Participation in this Plan or any Component Plans by an Employee shall not constitute an express or implied contract of employment between the Employer and the Employee.

11.2 **No Guarantee of Tax Consequences**. Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Beneficiary will be excludable from the gross income of such person 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 or Beneficiary. It shall be the obligation of each Participant and Beneficiary to determine whether any payment under this Plan or any Component Plan is excludable from gross income for federal and state income tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. Neither the Employer nor the Plan Administrator is liable for any taxes or penalties owed by any Participant or Beneficiary with respect to such amounts.

11.3 **Additional Taxes or Penalties**. If there are any taxes or penalties payable by the Employer on behalf of any Employee, such taxes or penalties shall be payable by the Employee to the Employer to the extent such taxes would have been originally payable by the Employee had this Plan not been in existence.

11.4 **Compliance with State and Federal Mandates**. With respect to component benefit plans, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as GINA, USERRA, FMLA, COBRA, HIPAA, NMHPA, WHCRA, MHPA, MHPAEA, HITECH, and Michelle's Law. Additional information regarding your rights under these and other applicable laws are set forth in the Plan's SPD.

11.5 **No Rights Against Employer**. Neither the establishment of the Plan or a Component Plan, any modification of the Plan or a Component Plan, nor any distributions from the Plan or a Component Plan shall be construed as giving to any current or former Employee, Participant or Beneficiary under the Plan or a Component Plan any legal or equitable rights against the Employer, its shareholders, directors or officers, as such, or as giving any person the right to be retained in the employ of the Employer.

11.6 **Payments Due Minors or Incapacitated Persons**. If any person entitled to a payment under this Plan or a Component Plan is a minor, or if the Plan Administrator determines that any such person is incapacitated by reason of physical or mental disability, whether or not legally adjudicated as incompetent, the Plan Administrator shall have the power to cause the payment to be made to another for his benefit, without responsibility of the Plan Administrator, the Employer, or any other person or entity to see to the application of such payment. Payments made pursuant to this power shall operate as a complete discharge of the Plan Administrator, the Employer, and the Plan.

EXHIBIT A

ARTICLE XII.
ADMINISTRATIVE INFORMATION

12.1 **Exclusive Benefit and Legal Enforceability**. This Plan is maintained for the exclusive benefit of Participants and Beneficiaries. The Employer intends that the terms of this Plan, including those relating to coverage and benefits, are legally enforceable.

12.2 **Plan Identification Number**. The Identification Number for this Plan is 501.

12.3 **Plan Sponsor and Employer Identification Number**. The plan sponsor for the medical, dental, and wellness program benefits is Educators Health Alliance. The Educators Health Alliance Employer Identification Number is 47-0839540. The plan sponsor for the all other benefits under this Plan is Board of Trustees of the Nebraska State Colleges. The Board of Trustees of the Nebraska State Colleges Employer Identification Number is 61-1573095.

12.4 **Administration**. The Employer is the Plan Administrator, unless the Employer designates another party as the Plan Administrator, and provided that the Educators Health Alliance is the Plan Administrator for medical, dental, and wellness program benefits. The Employer's name and address are as follows:

Board of Trustees of the Nebraska State Colleges
c/o Vice Chancellor for Employee Relations
1327 H. St., Suite 200
Lincoln, NE 68508
402-471-2505

The Educators Health Alliance name and address are as follows:

Educators Health Alliance
P.O. Box 82003
Lincoln, NE 68501
1-866-465-1342

Each Component Plan is administered pursuant to an insurance contract, pursuant to a service agreement, by the Educators Health Alliance, or by the Employer, as specified in the Component Plan itself.

12.5 **Agent for Service of Legal Process**. The name and address of the Plan's agent for service of legal process is the Plan Administrator.

12.6 **Participating Employers**. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator. Each Participating Employer may cease to participate in the Plan or in any Component Plan with respect to its Employees or former Employees by resolution of its governing body. Participating Employers are listed in Exhibit D.

12.7 **National Medical Support Notices**. To the extent required by law, if an Employee's Dependent is an "**alternate recipient**" described in a National Medical Support Notice ("NMSN"),

and if the Plan Administrator determines the order to be an appropriately completed NMSN, this Plan and the applicable Component Plan will provide Benefits to such Dependent.

IN WITNESS WHEREOF, this Plan has been duly executed as of the day and year written below.

BOARD OF TRUSTEES OF THE NEBRASKA STATE COLLEGE SYSTEM

_____
(Signature)

_____
(Print name)

_____
(Print title)

_____
(Date)

EXHIBIT A

EXHIBIT A

COMPONENT PLANS

COMPONENT PLANS
Medical
Dental
Vision
Life Insurance
Dependent Life Insurance
Supplemental Life Insurance
Accidental Death and Dismemberment
Long-Term Disability Insurance
Health FSA
Dependent Care FSA
HRA
Retired Employee HRA
Wellness Program
Employee Assistance Plan
Pre-Tax Premiums (Cafeteria Plan)

EXHIBIT A

EXHIBIT B

ELIGIBILITY

COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Medical	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Dental	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Vision	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Dependent Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire

EXHIBIT A

COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Supplemental Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Accidental Death & Dismemberment	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Long-Term Disability Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Health FSA	Active, full-time Employees working an average of 30 hours per week	None	Date of hire, or first of the month following date of hire if payroll has already finaled
Dependent Care FSA	Active, full-time Employees working an average of 30 hours per week	None	Date of hire, or first of the month following date of hire if payroll has already finaled
HRA	Active, full-time Employees working an average of 30 hours per week who are enrolled in the High Deductible Health Plan	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Retired Employee HRA	Retired Employees approved to retire under the Voluntary Retirement Settlement Program or the Early Retirement Settlement Program, and enrolled in the High Deductible Health Plan prior to retirement.	None	Date of retirement

EXHIBIT A

COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Wellness Program	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Employee Assistance Plan	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Pre-Tax Premiums (Cafeteria Plan)	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire

EXHIBIT A

EXHIBIT C

CERTIFICATES OF COVERAGE/BOOKLETS

ATTACHMENT #	COMPONENT PLANS	CERTIFICATE OF COVERAGE/BOOKLETS
1	Medical	Summary of Benefits and Coverage
2	Dental	Overview of Benefits
3	Vision	Insurance Policy and Certificate
4	Life Insurance	Insurance Policy and Certificate
5	Dependent Life Insurance	Insurance Policy and Certificate
6	Supplemental Life Insurance	Insurance Policy and Certificate
7	Accidental Death & Dismemberment	Insurance Policy and Certificate
8	Long-Term Disability Insurance	Insurance Policy and Certificate
9	Health FSA	Health FSA Policy
10	Dependent Care FSA	Dependent Care FSA Policy
11	HRA	HRA Plan Document and HRA Summary of Benefits and Coverage
12	Retired Employee HRA	Retired Employee HRA Plan Document
13	Wellness Program	EHA Wellness Program Policy
14	Employee Assistance Plan	Employee Assistance Plan Policy
15	Pre-Tax Premiums (Cafeteria Plan)	Cafeteria Plan Document

EXHIBIT A

EXHIBIT D

PARTICIPATING EMPLOYERS

Chadron State College

Peru State College

Wayne State College

System Office

EXHIBIT A

EXHIBIT E

CLAIMS ADMINISTRATION

For Claims On	Contact
Medical	Blue Cross Blue Shield of Nebraska PO Box 3248 Omaha, NE 68180-0001 877-721-2583
Dental	
Wellness Program	
Vision	Eyemed Attn: OON Claims PO Box 8504 Mason, OH 45040-7111 866-939-3633
Life Insurance	Madison National Life Insurance PO Box 2865 Clinton, IA 52733-2865 800-356-9601
Dependent Life Insurance	
Supplemental Life Insurance	
Accidental Death and Dismemberment	
Long-Term Disability Insurance	
Health FSA	ASI PO Box 6044 Columbia, MO 65205-6044 888-659-3035
Dependent Care FSA	
HRA	MidAmerica 402 South Kentucky Ave., Suite 500 Lakeland, FL 33801 800-430-7999
Retired Employee HRA	
Employee Assistance Plan	Continuum 1135 M Street, #400 Lincoln, NE 68508 800-755-7636
Pre-Tax Premiums (Cafeteria Plan)	Board of Trustees of the Nebraska State Colleges c/o Vice Chancellor for Employee Relations 1327 H. St., Suite 200 Lincoln, NE 68508 402-471-2505

EXHIBIT B

NEBRASKA STATE COLLEGE SYSTEM

HEALTH AND WELFARE PLAN

PLAN NUMBER 501

SUMMARY PLAN DESCRIPTION

Effective September 1, 2019

EXHIBIT B

TABLE OF CONTENTS

EXHIBIT B

1. General Plan Information

This document, along with the benefits booklets and certificates, and provider contracts, policies and descriptions, is the summary plan description ("SPD") for the Nebraska State College System Health and Welfare Plan (the "Plan"). These documents describe the Plan as in effect on September 1, 2019. The Plan may be changed from time-to-time.

For additional information regarding the Plan, you should contact the Vice Chancellor of Employee Relations at 402-471-2505 or refer to the official Plan documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

GENERAL PLAN INFORMATION	
Type of Plan and component benefit programs	The Plan is an umbrella plan known as a wraparound plan that provides the following welfare benefits: Cafeteria Plan; Health FSA Plan; Dependent Care FSA; HRA; Retired Employee HRA; Medical Benefits; Dental Benefits; Vision Benefits; LTD Insurance; Life, Dependent Life, Supplemental Life and AD&D Insurance; Wellness Program Benefits; and Employee Assistance Plan Benefits This is a governmental plan not subject to ERISA.
Plan Name	NEBRASKA STATE COLLEGE SYSTEM HEALTH AND WELFARE PLAN
Plan Number	501
Plan Year	SEPTEMBER TO AUGUST
Effective Date	The effective date of the most recent Plan amendment/ restatement is September 1, 2019. The Plan has been amended several times since its original effective date of September 1, 2001.
Plan Sponsor	**For medical, dental, and wellness program benefits**: Educators Health Alliance P.O. Box 82003 Lincoln, NE 68501 1-866-465-1342 **For all other benefits under the Plan**: Board of Trustees of the Nebraska State Colleges c/o Vice Chancellor for Employee Relations 1327 H. St., Suite 200 Lincoln, NE 68508 402-471-2505
Plan Sponsor's Employer Identification Number	**For medical, dental, and wellness program benefits**: EIN: 47-0839540 **For all other benefits under the Plan**: EIN: 61-1573095
Plan Administrator	**For medical, dental, and wellness program benefits**:

EXHIBIT B

GENERAL PLAN INFORMATION	
	Educators Health Alliance P.O. Box 82003 Lincoln, NE 68501 1-866-465-1342 **For all other benefits under the Plan**: Board of Trustees of the Nebraska State Colleges c/o Vice Chancellor for Employee Relations 1327 H. St., Suite 200 Lincoln, NE 68508 402-471-2505
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan Administration	Component Benefits available under the Plan are administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers or providers who provide and guarantee the benefits. Self-insured or unfunded benefits, if any, are paid from the Employer's general assets.
Network	The provider network is described generally in Attachments, attached hereto as Exhibit D, as applicable.
Claims Administration	The claims procedures for each Benefit are set forth in the Certificate of Coverage or Booklet for the applicable Component Plan. In the event that the claims procedures are not set forth, or in the event that the claims procedures do not comply with applicable law, the claims procedures set fort in Exhibit A shall apply.

2. Purpose

The purpose of the Plan is to provide a variety of health and welfare benefits for the exclusive benefit of eligible Employees and their spouses and dependents. The Plan is an umbrella plan that provides a variety of benefits through the following component benefit programs list above. Some of these component benefit programs require completion of application forms, annual elections, and/or other administrative forms. The details of these administrative requirements are described in the Attachments.

Each of the component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description ("SPD") prepared specifically for that component benefit program, or another written governing document prepared by the Company. A copy of each booklet, summary, or other governing document is attached to this document in Exhibit D. Detailed information on the benefits offered under the Plan may be found in the insurance contracts, evidence of coverage, or the official plan documents for each benefit.

Not all of the component benefit programs are subject to the same laws. They are described as part of the Plan for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document.

Certain of the benefits provided by the Plan are "health plans" and thereby subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations effecting the maintenance, creation or use of Protected Health Information. Please refer to the Notice of Privacy Practices issued by your health plan for a description of how medical information about you may be used and disclosed and how you can get access to this information.

Purpose of This Wrap SPD Document

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Attachments. This document, together with the Attachments, is the SPD. This document is not intended to give you any substantive rights to benefits that are not already provided by the Attachments. If you have not received a copy of the Attachments, contact the Vice Chancellor for Employee Relations of Board of Trustees of the Nebraska State Colleges. You must read the Attachments and this Wrap SPD to understand your benefits!

Alienation

No Benefits under the Plan may be subject to anticipation, garnishment, attachment, execution or levy of any kind, or be liable for any Participant's or Beneficiary's debts or obligations.

Important Disclaimer

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Company. If the terms of this Wrap SPD document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this Wrap SPD document, unless otherwise required by law or as otherwise determined by the Plan Administrator.

3. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to a particular type of coverage under the Plan and the Participant makes the required employee contribution for the coverage selected. The Plan Administrator will inform you of the amount of required employee contributions, if any, for each type of coverage.

For purposes of group health plan coverage under the Patient Protection and Affordable Care Act ("PPACA"), an eligible Employee is a person who is classified by the Employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, but for purposes of the Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.

For purposes of the Plan, eligibility requirements are used only to determine your initial eligibility for coverage under the Plan. You may retain eligibility for coverage under the Plan if you are temporarily absent on an approved leave of absence, with the expectation of returning to work

following the approved leave as determined by the Employer's leave policy, provided that contributions continue to be paid on a timely basis. For purposes of group health plan coverage, Employees who meet eligibility requirements during a measurement period as required by the PPACA regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the PPACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the Employer agrees to such reclassification, will change a person's eligibility for benefits.

The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Attachments for the applicable component benefit programs. If such terms and conditions do not appear in those Attachments, then the eligibility provisions set forth on Exhibit B shall apply.

Cessation and Reinstatement of Participation

If a Participant ceases to be an eligible Employee, participation in the Plan (or component benefit program) shall terminate. Participation in the Plan may thereafter be renewed upon satisfaction of the eligibility requirement contained in this Section 3.

Notwithstanding the foregoing, for purposes of group health plan eligibility, if your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you qualify for eligibility under the Plan again (are rehired or considered to be rehired for purposes of the PPACA) within 26 weeks from the date coverage ended, your coverage will be reinstated. If your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you do not qualify for eligibility under the Plan again (is not rehired or considered to be rehired for purposes of the PPACA) within 26 weeks from the date your coverage ended, and you did not perform any hours of service that were credited within the 26-week period, you will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact the Plan Administrator.

Need for Enrollment: Time Limits

In general, eligible Employees must complete an application form (available through the Vice Chancellor for Employee Relations of Board of Trustees of the Nebraska State Colleges) to enroll themselves and/or their eligible spouses and dependents. New Employees must generally enroll within certain time periods after being hired, as described in the Attachments. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before September 1st of each year.

Special Enrollment Rights

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"). For instance, if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plan if you or your dependents lose

eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator. Additional details regarding special enrollment rights are explained in the Attachments.

When Participation Begins

Once you, as an eligible Employee, have completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the Attachments.

Termination of Participation

In general, your coverage under the Plan terminates on the last day of the month in which you terminate employment with the Company or in accordance with the applicable component benefit program, whichever is earlier. Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the Attachments.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the Attachments (for example, divorce or a dependent's attaining age limit). Coverage also ceases for Employees, spouses, and dependents upon termination of the Plan.

Coverage under a particular component benefits program stops according to the terms and conditions reflected in the Attachments. Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program.

The medical component plans in the Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except where an individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted by law.

4. Summary of Plan Benefits

Available Benefits and Contributions

The Plan provides you and your eligible spouse and/or dependents with certain benefits. A summary of each component benefit program provided under the Plan is set forth in the Attachments listed in Exhibit D.

In general, the cost of the benefits provided through the component benefit programs may be funded in part by Company contributions and in part by pre-tax Employee contributions through the Cafeteria Plan. The Company will determine and periodically communicate your share of the

cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions 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. With respect to the insured component benefit programs, the Company will pay its contribution and your contributions to the insurer. With respect to benefits that are self-funded, the Company 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 will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

National Medical Support Notices

With respect to the component benefit programs, the Plan extends benefits to an Employee's non-custodial child, as required by any appropriately completed National Medical Support Notice.

Administrative Requirements and Timelines

As described in the Attachments, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the Attachments.

5. How the Plan Is Administered

Plan Operations

The Plan is administered by Educators Health Alliance, Board of Trustees of the Nebraska State Colleges, and the insurance companies.

Plan Administration

Educators Health Alliance is the Plan Administrator for medical, dental, and wellness program benefits. The Board of Trustees of the Nebraska State Colleges is the Plan Administrator for all other benefits under the Plan, unless the Employer designates another person or committee to hold the position of Plan Administrator. The Plan Administrator has agreed to indemnify the Plan Administrator delegates for any liability incurred as a result of carrying out the duties set forth herein, unless such liability is due to gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and 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, authorizing benefit payments, and gathering information necessary for administering the Plan. 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 may appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan. The Plan Administrator has the discretionary authority to carry out its duties set forth herein. 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. All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

Third Party Recovery

In the event Participants or Beneficiaries received benefits from another welfare benefit plan, the Plan may be entitled to reimbursement. In particular, the Plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

Power and Authority of Insurance Companies

Certain benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between Educators Health Alliance or Board of Trustees of the Nebraska State Colleges and the Insurance Companies. Claims for benefits are sent to the Insurance Companies. The Insurance Companies are responsible for determining and paying claims, not Educators Health Alliance or Board of Trustees of the Nebraska State Colleges.

The Insurance Companies are responsible for: (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

As the Named Fiduciary for benefit determinations, the Insurance Companies have the discretionary authority to interpret the Plan in order to make benefit determinations. The Insurance Companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan, or the amount of any benefit payable under the self-funded component benefit plans), please contact the Vice Chancellor for Employee Relations, who acts on behalf of Board of Trustees of the Nebraska State Colleges.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate Insurance Company.

6. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriate you (or your dependent or Beneficiary) shall be responsible for refunding the overpayment to the Plan, in accordance with the terms of the Plan incorporated in this SPD by reference.

The Attachments contain specific provisions as to limitations, exclusions, and restrictions on benefits. In addition, any pre-existing condition limitation is described in the Attachments. Please refer to them when checking to see if a particular condition is covered by the Plan.

7. Amendment or Termination of the Plan

Amendment or Termination

The Plan Sponsor has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument approved by the Company and executed by a duly authorized officer of the Company provided such amendment applies only to claims not yet incurred and is communicated to those Participants participating in the Plan.

The Company or its delegate may sign insurance contracts for the Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that are administrative in nature or advisable in order to comply with applicable law.

Duration and Employer's Right to Discontinue Plan and Contributions

This Plan is established with the intention of being maintained for an indefinite period of time. Nevertheless, the Company expressly reserves the right to discontinue or terminate the Plan with respect to claims not yet incurred and make no further contributions. No Employee, dependent, of Beneficiary shall have or attain any vested right, contractual or otherwise, to any further contributions to the Plan by the Company after the Company has discontinued or terminated the Plan.

8. No Contract of Employment

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.

9. Claims Procedures

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, 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 the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component 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. (*See* the Attachments for more information.)

The insurer will decide your claim in accordance with its reasonable claims procedures and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan). (See the Attachments for more information.) In the event an Attachment does not include claims procedures, the claims procedures set forth in Exhibits A shall be followed.

Claims Procedure For Benefits Based On Determination Of Disability

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days, provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. During the pendency of an appeal, you have the right to review and respond to new information before a final decision is made. You are entitled to any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim, free of charge. You will also be provided with reasonable opportunity to respond to the evidence or rationale before a decision is announced.

A claim denial notice will contain the reason the claim was denied, a reference to the specific provisions of the Plan on which the denial was based, a description of any additional

material or information necessary to perfect the claim and an explanation for why this material or information is necessary, a description of the appeals procedures. It will also contain information on any internal rules, guidelines, protocols, or other criterion relied upon in deciding the claim, and information on any exclusion or limits based on medical necessity or experimental treatment. A notice of a disability claim denial will contain a discussion of the decision that includes the basis for disagreeing with a health care professional or vocational professional, including the information received but not relied upon, and the basis for disagreeing with a Disability determination by the Social Security Administration. A notice of a disability claim denial will also contain a description of any applicable contractual limitations periods applying to the claimant's right to bring an action, as well as the calendar date upon which any rights expire.

All claim and appeals are decided independently and impartially. You have the right to receive, upon request and free of charge, reasonable access to and copies of the entire claim file and other relevant documents.

10. Legal Notices

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the updated summary plan description ("SPD"). The Plan Administrator may make a reasonable charge for the copies.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. A notice explaining your continuation coverage rights is set forth later on in this Section.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Enforce Your Rights

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

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. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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 by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE UNDER COBRA

Under a federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), group health plans of most employers with 20 or more employees are required to offer covered Employees, their covered Spouses and Dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension. Domestic partners should contact the Plan Administrator to discuss eligibility for continuation coverage.

As an Employee covered under the Plan, you have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your Spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses Dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your Spouse divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted by, or placed for adoption with the covered Employee during the continuation coverage period is also entitled to elect COBRA continuation coverage. Such child's coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee's COBRA coverage. You must notify the Plan Administrator within 30 days and provide supporting documentation.

Under COBRA, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator by filing a Change of Status notice with the Plan Administrator within 60 days after:

- You and your Spouse are divorced or legally separated; or
- One of your children loses Dependent status under the Plan.

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period. However, you (or your Spouse or dependent child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of the total premium paid by you and your Employer for that level of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Spouse or dependent child, if applicable) lose health coverage under the Plan because your employment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the

date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.) If during those 18 months, another qualifying event takes place that entitles your Spouse (or dependent child, if applicable) to continuation health coverage, your Spouse's continuation coverage (or dependent child's continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your Spouse's health continuation coverage (or your dependent child's health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event. If your covered Spouse and/or dependent child lose coverage due to your termination of employment (for reasons other than gross misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in Medicare, then the maximum continuation coverage period for your Spouse and dependent child shall be 36 months from the date you enrolled in Medicare.

Disability is a special issue. If the Social Security Administration determines that you (or your Spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after a child's birth, adoption or placement for adoption, then your continuation coverage period as well as your Spouse's and any Dependent's continuation periods may be extended from 18 months to 29 months. The Employer may charge up to 150% of the total premium paid by you and the Employer during this extended period. To qualify, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator in writing within 60 days of the date of the Social Security Administration determination and during the initial 18 month continuation coverage period. Your written notice must include your name, Social Security Number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the Employer will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage was the bankruptcy of the Employer under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until the death of the covered retired employee. Covered spouses, surviving spouses and dependents of the covered retired employee will have the opportunity to elect continuation health coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

Your right to continuation health coverage (or your Spouse's or dependent child's right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect

to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);

- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

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

There may be other coverage options for you and your family. For example, you may buy coverage through a Health Insurance Marketplace. In the Marketplace, you could be eligible for a special kind of tax credit that lowers your monthly premiums. Being eligible for COBRA does not limit your eligibility for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Additional continuation rights may apply under state law. Please contact the Plan Administer for further information.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights, including under 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") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

COBRA Administrator Information

For medical, dental, and wellness program benefits:

Payflex
11819 Miami St., Suite 200
Omaha, NE 68164
844-729-3539

For all other benefits under the Plan:

ASI COBRA
P.O. Box 657
Columbia, MO 65205
877-388-8331

Plan Administrator Contact Information

For **medical, dental, and wellness program benefits:**

Educators Health Alliance
P.O. Box 82003
Lincoln, NE 68501
866-465-1342

For all other benefits under the Plan:

Board of Trustees of the Nebraska State Colleges
c/o Vice Chancellor for Employee Relations
1327 H. St., Suite 200
Lincoln, NE 68508
402-471-2505

11. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Company 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 Company.

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA") NOTICE

Notwithstanding any rule regarding termination of participation or any other provision to the contrary in the Plan, if you go on a qualifying leave under FMLA, the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), Educators Health Alliance and Board of Trustees of the Nebraska State Colleges shall continue to maintain your health benefits on the same terms and conditions as though you were still an active Employee. Except as otherwise provided by the FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse the Company for the cost of the coverage the Company provided you while you were on FMLA leave (the cost equals the COBRA premium, without the 2% add-on). The FMLA includes the following additional leave rights:

- Eligible Employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the Employee is on active military duty or a reservist being called to active military duty in the Armed Forces and is deployed to a foreign country

- An eligible Employee who is the spouse, son, daughter, parent, or next of kin of an eligible covered service member as defined below is entitled to up to 26 work weeks of leave in a single 12-month period to care for the service member. For purposes of this provision, eligible covered service member shall mean a veteran who was a member of the Armed Forces (including a member of the National Guard or a military reservist) who are undergoing medical treatment, recuperation, or therapy for a serious illness or injury that occurred while in the military during the five-year period preceding treatment.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA") RIGHTS NOTICE

Federal law may also afford certain Participants and their Dependents the right to continue their health care coverage during certain periods of military leaves of absence pursuant to USERRA. This continuation option is similar in many respects to COBRA continuation coverage. For example, the benefits affected by this continuation coverage option are the same as described above. The maximum time periods for such coverage, however, shall be the lesser of:

- the 24-month period beginning on the day the Participant's military leave of absence begins, or

- the period beginning on the day the Participant's military leave of absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment with the Company pursuant to the Participant's rights under USERRA.

One hundred and two percent (102%) of the applicable premium must be paid for the continuation coverage unless the period of military service is for not more than 31 days, in which event only the same contributions required from an active Employee for similar coverage must be paid. The notice requirements that apply to COBRA in the case of termination of employment also apply in the case of continuation coverage during military leaves.

Upon the reinstatement of coverage after reemployment no waiting period or other exclusions shall apply that would not have otherwise applied if coverage had terminated for any reason other than military service in the U.S. uniformed services. Furthermore, coverage under the Plan shall not apply to any illness or injury the U.S. Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the U.S. uniformed services.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP") NOTICE

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in Exhibit C, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT ("NMHPA") NOTICE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ("WHCRA") NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 ("MHPAEA") NOTICE

All group health care coverage maintained under the Plan, which provide both medical and surgical benefits and offer mental health or substance use disorder benefits there under shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA") NOTICE

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask that you not provide any genetic information when responding to any request for medical information. 'Genetic information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistance reproductive services.

EXHIBIT B

HIPAA NOTICE OF PRIVACY PRACTICES NOTICE

HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither the Plan nor the employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, 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.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

EXHIBIT B

Exhibit A–Claims Procedures

COMPONENT BENEFIT PROGRAM CLAIMS ADMINISTRATORS

For Claims On	Contact
Medical Dental Wellness Program	Blue Cross Blue Shield of Nebraska PO Box 3248 Omaha, NE 68180-0001 877-721-2583
Vision	Eyemed Attn: OON Claims PO Box 8504 Mason, OH 45040-7111 866-939-3633
Life Insurance Dependent Life Insurance Supplemental Life Insurance Accidental Death and Dismemberment Long-Term Disability Insurance	Madison National Life Insurance PO Box 2865 Clinton, IA 52733-2865 800-356-9601
Health FSA Dependent Care FSA	ASI PO Box 6044 Columbia, MO 65205-6044 888-659-3035
HRA Retired Employee HRA	MidAmerica 402 South Kentucky Ave., Suite 500 Lakeland, FL 33801 800-430-7999
Employee Assistance Plan	Continuum 1135 M Street, #400 Lincoln, NE 68508 800-755-7636
Pre-Tax Premiums (Cafeteria Plan)	Board of Trustees of the Nebraska State Colleges c/o Vice Chancellor for Employee Relations 1327 H. St., Suite 200 Lincoln, NE 68508 402-471-2505

EXHIBIT B

DEFAULT CLAIMS PROCEDURES

Introduction

These claims procedures are furnished as a separate document that accompanies the Nebraska State College System Health and Welfare Plan Document and Summary Plan Description ("SPD").

Claims Procedures For The Plan

Except as provided below, claims for benefits under each Plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) 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 receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

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 Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

Claims Procedure For Benefits Based On Determination Of Disability

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days, provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period. You have 180 days to appeal an adverse benefit determination. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

Claims Procedures For Group Health Plans

The following claims procedures shall apply specifically to claims made under any group health plan under the Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the

information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.

- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

Judicial Review

Upon completion of these procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for Plan benefits must be filed not later than 24 months after completion of the Plan's internal claims procedures (and external review, if applicable).

EXHIBIT B

Exhibit B - Eligibility

Summary of Eligibility and Participation Provisions

COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Medical	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Dental	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Vision	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire
Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire

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COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Dependent Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Supplemental Life Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Accidental Death & Dismemberment	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Long-Term Disability Insurance	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Health FSA	Active, full-time Employees working an average of 30 hours per week	None	Date of hire, or first of the month following date of hire if payroll has already finaled.
Dependent Care FSA	Active, full-time Employees working an average of 30 hours per week	None	Date of hire, or first of the month following date of hire if payroll has already finaled.
HRA	Active, full-time Employees working an average of 30 hours per week who are enrolled in the High Deductible Health Plan	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire

EXHIBIT B

COMPONENT BENEFIT	ELIGIBLE EMPLOYEE	WAITING PERIOD	EFFECTIVE DATE OF COVERAGE
Retired Employee HRA	Retired Employees approved to retire under the Voluntary Retirement Settlement Program or the Early Retirement Settlement Program, and enrolled in the High Deductible Health Plan prior to retirement.	None	Date of retirement
Wellness Program	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Employee Assistance Plan	Active, full-time Employees working an average of 30 hours per week	None	Date of hire
Pre-Tax Premiums (Cafeteria Plan)	Active, full-time Employees working an average of 30 hours per week	None	First of the month following date of hire, unless the date of hire is the first day of the month then coverage is immediately available on the date of hire

EXHIBIT B

Exhibit C - CHIP Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	**GEORGIA - Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS - Medicaid	**INDIANA - Medicaid**

EXHIBIT B

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS - Medicaid	**NEW HAMPSHIRE - Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY - Medicaid	**NEW JERSEY - Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA - Medicaid	**NEW YORK - Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE - Medicaid	**NORTH CAROLINA - Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS - Medicaid and CHIP	**NORTH DAKOTA - Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA - Medicaid	**OKLAHOMA - Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

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Phone: 1-800-657-3739	
MISSOURI - Medicaid	**OREGON - Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA - Medicaid	**PENNSYLVANIA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA - Medicaid	**RHODE ISLAND - Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA - Medicaid	**SOUTH CAROLINA - Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	**WEST VIRGINIA - Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid and CHIP	**WISCONSIN - Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT- Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA - Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924	

CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

EXHIBIT B

Exhibit D – Attachments

See attached.

ATTACHMENT #	COMPONENT PLANS	CERTIFICATE OF COVERAGE/BOOKLETS
1	Medical	Summary of Benefits and Coverage
2	Dental	Overview of Benefits
3	Vision	Insurance Policy and Certificate
4	Life Insurance	Insurance Policy and Certificate
5	Dependent Life Insurance	Insurance Policy and Certificate
6	Supplemental Life Insurance	Insurance Policy and Certificate
7	Accidental Death & Dismemberment	Insurance Policy and Certificate
8	Long-Term Disability Insurance	Insurance Policy and Certificate
9	Health FSA	Health FSA Policy
10	Dependent Care FSA	Dependent Care FSA Policy
11	HRA	HRA Plan Document and HRA Summary of Benefits and Coverage
12	Retired Employee HRA	Retired Employee HRA Plan Document
13	Wellness Program	EHA Wellness Program Policy
14	Employee Assistance Plan	Employee Assistance Plan Policy
15	Pre-Tax Premiums (Cafeteria Plan)	Cafeteria Plan Document

EXHIBIT C

NEBRASKA STATE COLLEGE SYSTEM

FLEXIBLE BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Restated Effective September 1, 2019

EXHIBIT C

ARTICLE I. Introduction

1.1 Establishment of Plan

The Board of Trustees of the Nebraska State Colleges originally established the Nebraska State Colleges Flexible Benefit Plan effective October 1, 1987 and later adopted a Medical Reimbursement Plan and Dependent Care Expense Reimbursement Plan both originally effective September 1, 2001. The Board of Trustees of the Nebraska State Colleges hereby amends and restates the plans into one comprehensive plan document effective September 1, 2019. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions under the Medical, Vision, Dental, and/or Long-Term Disability Plan on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to an Employee's Health FSA Account for reimbursement of certain Medical Care Expenses, and/or to a DCAP Account for reimbursement of certain Dependent Care Expenses.

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan document and related summary plan description under Code §125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The DCAP Component is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of HIPAA, and COBRA. In the event that the Health FSA Component is determined not to be a separate plan, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the Health FSA Component. The Medical, Vision, Dental, and Long-Term Disability Insurance Plans, and Health FSA are intended to be part of an organized health care arrangement for purposes of HIPAA.

ARTICLE II. Definitions

2.1 Definitions

Account(s) means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs, and Section 9.5 for DCAPs.

Benefits means the Premium Payment Benefits, the Health FSA Benefits and the DCAP Benefits offered under the Plan.

Benefits Committee means the committee appointed by the Plan Administrator that is responsible for the administration, operation, and interpretation of this Plan.

Benefit Package Option means a qualified benefit under Code §125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan). Benefits prohibited under Code §125(f) (such as long-term

care insurance and certain Exchange-participating qualified health plans) are not permitted Benefit Package Options.

Change in Status means any of the events described below, as well as any other events included in subsequent changes to Code §125, or regulations or guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under applicable law and under this Plan:

(a) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

(d) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, or any similar circumstance; and

(e) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents.

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

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

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code §132(f)(4) plan; but determined after (d) any salary deferral elections under any Code §401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

Component(s) means one or more of the following: the DCAP Component, the Health FSA Component or the Premium Payment Component.

Contributions means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, and Section 9.2 for DCAP Benefits.

DCAP means dependent care assistance program.

DCAP Account means the account described in Section 9.5.

DCAP Benefits has the meaning described in Section 9.1.

DCAP Component means the component of this Plan described in Article IX.

Dental Insurance Benefits means the Employee's Dental Insurance Plan coverage for purposes of this Plan.

EXHIBIT C

Dental Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing dental type benefits through a group insurance policy or policies, if separate from the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Dependent means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 9.3.

Earned Income shall have the meaning given such term in Code §129(e)(2).

Effective Date of this Plan means the effective date of this restatement, September 1, 2019.

Election Form/Salary Reduction Agreement means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits, and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions. If an interactive voice-response system or web-based program is used for enrollment, the Election Form/Salary Reduction Agreement may be maintained on an electronic database in accordance with applicable laws.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Section 3.1.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or individual classified by the Employer as an independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer means the Board of Trustees of the Nebraska State Colleges and any Related Employer that adopts this Plan with the approval of the Board of Trustees of the Nebraska State Colleges. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Articles IX and XIV and Section 15.3, "Employer" means only the Board of Trustees of the Nebraska State Colleges.

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Health FSA means health flexible spending arrangement.

EXHIBIT C

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

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

HMO means the health maintenance organization Benefit Package Option (if any) under the Medical Insurance Plan.

Long-Term Disability Benefits means the Employee's Long-Term Disability Plan coverage for purposes of this Plan.

Long-Term Disability Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing long-term disability type benefits through a group insurance policy or policies, if separate from the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Medical Care Expenses has the meaning described in Section 7.3.

Medical Insurance Benefits means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

Medical Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing major medical-type benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Open Enrollment Period with respect to a Plan Year means the month of August in the year preceding the Plan Year, or such other period as may be prescribed by the Administrator.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include those who elect one or more of the Premium Payment Benefits, Health FSA Benefits, DCAP Benefits, and Salary Reductions to pay for such Benefits.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

Plan means the Nebraska State Colleges Flexible Benefit Plan as set forth herein and as amended from time to time.

Plan Administrator means Educators Health Alliance for Medical Insurance Benefits and Dental Insurance Benefits, and the Board of Trustees of the Nebraska State Colleges for all other Benefits under the Plan. The contact person is the Vice Chancellor for Employee Relations for the Nebraska State Colleges, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Benefits Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

Plan Year means the 12-month period commencing each September 1 and ending on the following August 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

PPO means the preferred provider organization Benefit Package Option (if any) under the Medical Insurance Plan.

Premium Payment Benefits means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

Premium Payment Component means the component of this Plan described in Article VI.

QMCSO means a qualified medical child support order.

Qualifying Dependent Care Services has the meaning described in Section 9.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1); (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

Related Employer means any employer affiliated with the Nebraska State Colleges that, under Code §414(b), §414(c), or §414(m), is treated as a single employer with Nebraska State Colleges for purposes of Code §125(g)(4).

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the DCAP Component, the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a Qualifying Individual's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

Vision Insurance Benefits means the Employee's Vision Insurance Plan coverage for purposes of this Plan.

Vision Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing vision type benefits through a group insurance policy or policies, if separate from the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

EXHIBIT C

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan (including the Premium Payment Component, the Health FSA Component, and the DCAP Component) if the individual is an Employee and is eligible for the Medical/Dental/Vision/Long-Term Disability Insurance Plan (whether or not coverage under such plan has been elected). An Employee shall be eligible to participate in the Plan as of the first day of the month following his or her Employment Commencement Date. Where an Employee's Employment Commencement Date is the first day of the month, the Employee may elect to participate on his or her Employment Commencement Date.

Eligibility for Medical, Vision, Dental, and Long-Term Disability Insurance Premium Payment Benefits shall also be subject to the additional requirements, if any, specified in the Medical, Vision, Dental, and Long-Term Disability Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the termination of this Plan; or

(b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical, Vision, Dental, and Long-Term Disability Insurance Benefits will terminate as of the date(s) specified in the Medical, Vision, Dental, and Long-Term Disability Insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical, Vision, Dental, and Long-Term Disability Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require Participants to continue all Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, and Health FSA Benefits coverage while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue such coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical, Vision, Dental, and/or Long-Term Disability Insurance Benefits, and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days, vacation days and compensatory time, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- under another arrangement agreed upon between the Participant and the Plan Administrator upon the Participant's return.

The Employer requires all Participants to continue Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, and Health FSA Benefits during an unpaid FMLA leave. The Participant will be required to continue to pay Contributions during the leave.

If a Participant's Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a per-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when Participants are on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant, or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined

by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 12.3(d) will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan midyear may elect to commence participation in one or more Benefits on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical, Vision, Dental, and Long-Term Disability Insurance Plans.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide a paper or electronic Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a midyear election change, as described under Section 12.3 or 12.4.

Notwithstanding the foregoing, if a Participant fails to make his or her election with the Plan Administrator prior to the specified due date, but the Participant has previously elected Salary Reduction Benefits hereunder, Salary Reduction benefits shall be deemed to have continued such election in subsequent Plan Years until such time as the Participant affirmatively elects otherwise, unless the Employer requires an election form to be returned in a particular year and announces that requirement to the Participant directly or to Plan Participants generally. If such an announcement is made and an election form is not returned by the date specified by the Employer, the Participant will not participate in any of the Benefits or in this Plan and his or her share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a midyear election change as described under Section 12.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

EXHIBIT C

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII; and

(c) DCAP Benefits, as described in Article IX.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

(a) Employer Contributions. For Participants who elect Medical Insurance Benefits described in Article VI, the Employer will contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. There are no Employer contributions for Health FSA Benefits, or DCAP Benefits.

(b) Participant Contributions. Participants who elect any of the Medical Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits, or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, and Section 9.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component, or DCAP Component to the extent permitted under Section 12.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits, and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to 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 this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits, and Section 9.4(b) for DCAP Benefits.

ARTICLE VI. Premium Payment Component

6.1 Benefits

The Premium Payment Component offers benefits under the Medical Insurance Plan, providing major medical benefits, and the Vision, Dental and Long-Term Disability Insurance Plans. Notwithstanding any other provision in this Plan, the Medical, Vision, Dental, and Long-Term Disability Insurance Benefits are subject to the terms and conditions of the Medical, Vision, and Dental Insurance Plans, and no changes can be made with respect to such Medical, Vision, Dental, and Long-Term Disability Insurance Benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical, Vision, Dental, and/or Long-Term Disability Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits). Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates. A Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical, Vision, Dental, and/or Long-Term Disability Insurance Benefits that are provided to the Participant during the period that begins immediately following the close of that Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Benefits Provided Under the Medical, Vision, Dental, and Long-Term Disability Insurance Plans

Medical, Vision, Dental, and Long-Term Disability Insurance Benefits will be provided by the Medical, Vision, Dental, and Long-Term Disability Insurance Plans, not this Plan. The types and amounts of Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, the requirements for participating in the Medical, Vision, Dental, and Long-Term Disability Insurance Plans, and the other terms and conditions of coverage and benefits of the Medical, Vision, Dental, and Long-Term Disability Insurance Plans are set forth in the Medical, Vision, and Dental Insurance Plans. All claims to receive benefits under the Medical, Vision, Dental, and Long-Term Disability Insurance Plans shall be subject to and governed by the terms and conditions of the Medical, Vision, Dental, and Long-Term Disability Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical, Vision, and Dental Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical, Vision, and/or Dental Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she

had under the Medical, Vision, and/or Dental Insurance Plans the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for Medical, Vision, and Dental Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses under the Health FSA described in Section 7.3(b) (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), any such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the Health FSA Component unless he or she is also eligible for the Medical Insurance Plan.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) Incurred. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) Medical Care Expenses. "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical, Vision, Dental, and Long-Term Disability Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

(1) premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);

(2) medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);

(3) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or

(4) any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

7.4 Maximum and Minimum Benefits for Health FSA

(a) Maximum Reimbursement Available; Uniform Coverage. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after participation in this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

(b) Maximum and Minimum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $2,700, subject to Sections 7.4(c) and 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) Changes; No Proration. For Plan Years beginning after 2019, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code §125(i). If a Participant enters the Health FSA Component midyear or wishes to increase his or her election midyear as permitted under Section 12.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Code §125(i).

(d) Effect on Maximum Benefits If Election Change Permitted. Any change in an election under Article XII (other than under Section 12.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 12.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) Monthly Limits on Reimbursing OTC Drugs. Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII, including that it has been prescribed (unless it is insulin) and is for medical care under Code §213(d)); stockpiling is not permitted.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) Crediting of Accounts. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) Debiting of Accounts. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

(c) Available Amount Not Based on Credited Amount. As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule

(a) Use-or-Lose Rule. If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) Use of Forfeitures. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) Claims Substantiation. A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the December 15th following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section 7.10 and applicable IRS guidance regarding electronic payment card programs.

(c) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article XIII.

(d) Claims Ordering; No Reprocessing. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in this Section 7.8, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA, except that it shall not be terminated early for after-acquired group health coverage or Medicare entitlement.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 Named Fiduciary for Health FSA

The Board of Trustees of the Nebraska State Colleges is the named fiduciary for the Health FSA Component.

7.10 Electronic Payment Cards

If the Employer allows the Health FSA to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs. In addition, the following provisions shall apply:

(a) Initial and Periodic Certification. Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Medical Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other the terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other Health FSA claims. The Participant must reaffirm these agreements during each subsequent Open Enrollment Period in order for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.

(b) Deactivation of Card. A Participant's card will be deactivated when participation in the Health FSA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Medical Care Expenses through other methods (e.g., by submitting paper claims).

(c) Merchants; Card Use. Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available reimbursement as described in Section 7.4. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the Health FSA is being made is a Medical Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.

(d) Documentation. For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated.

(e) Correction of Improper Payments. Participants must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

ARTICLE VIII. RESERVED

ARTICLE IX. DCAP Component

9.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

9.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b). (For example, if the maximum $5,000 annual benefit amount is elected, then the annual Contribution amount is also $5,000.)

9.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) Incurred. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) Dependent Care Expenses. "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code §21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.

(c) Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) Exclusion. Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code §152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child as defined in Code §152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

9.4 Maximum and Minimum Benefits for DCAP

(a) Maximum Reimbursement Available. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior

reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article IX have been satisfied.

(b) Maximum and Minimum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;

- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse will be deemed to have earned income of at least $250 ($500 if the Participant has two or more Qualifying Individuals) for each month in which the Spouse is either (1) physically or mentally incapable of self-care (provided that the Spouse must have the same principal place of abode as the Participant for more than one-half of such year), or (2) a Student); or

- either $5,000 or $2,500 for the calendar year, as applicable:

  (1) $5,000 for the calendar year if one of the following applies:

  – the Participant is married and files a joint federal income tax return;

  – the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household; or

  – the Participant is single or is the head of the household for federal income tax purposes; or

  (2) $2,500 for the calendar year if the Participant is married and files a separate federal income tax return under circumstances other than those described above.

(c) Changes; No Proration. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component midyear or wishes to increase his or her election midyear as permitted under Section 12.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) Effect on Maximum Benefits If Election Change Permitted. Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

9.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

(a) Crediting of Accounts. A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) Debiting of Accounts. A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) Available Amount Is Based on Credited Amount. As described in Section 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements for Dependent Care Expenses incurred during the Plan Year--i.e., it is based on the amount credited to the DCAP Account at a particular point in time. Thus, a Participant's DCAP Account may not have a negative balance.

9.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

9.7 Reimbursement Claims Procedure for DCAP

(a) Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) Claims Substantiation. A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the December 15 following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, as described in Section 9.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;

- the name of the person, organization, or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);

- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and

- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

(c) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article XIII.

9.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant may receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates but before the end of the plan year, as long as such expenses are employment-related. However, the Participant may not make any further contributions to the DCAP account after termination of Participation and any unused amounts remaining in the DCAP account at the end of the plan year will be forfeited.

In addition, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim no later than December 15th following the close of the Plan Year in which the expenses were incurred.

9.9 Report to DCAP Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

ARTICLE X. HIPAA Provisions for Health FSA

10.1 General

As a HIPAA Health Plan, the Health FSA shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

10.2 Definitions

For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition,

access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §160.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Health FSA or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.3. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Health FSA, even though the employee's duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health FSA functions.

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

10.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health FSA. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA administration functions that the Employer performs on behalf of a Health FSA pursuant to Section 10.4.

(a) Employer employees who perform the following functions on behalf of the Health FSA are Responsible Employees: (1) claims determination and processing functions; (2) Health FSA vendor relations functions; (3) benefits education and information functions; (4) Health FSA administration activities; (5) legal department activities; (6) Health FSA compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health FSA HIPAA privacy officer and security official, and Employer employees to whom the Health FSA HIPAA privacy officer and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the health FSA's privacy notice; (5) response to requests by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Health FSA PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

10.4 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health FSA, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA's own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

(f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers' compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

10.5 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) Genetic Information. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) Employment-Related Actions. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) Other Benefits. Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 10.4, shall not be a permitted use or disclosure.

10.6 Certification Requirement

The Health FSA shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health FSA any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI 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 PHI and Electronic PHI infeasible;

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA and the Employer's activities in its role as Health FSA sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the FSA.

10.7 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

10.8 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Health FSA shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Health FSA shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE XI. [Reserved]

ARTICLE XII. Irrevocability of Elections; Exceptions

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Package Options (including the various Health FSA Options).

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.3 (or within 60 days of the occurrence of an event described in Section 12.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce) that results in a beneficiary becoming ineligible for coverage under Medical, Vision, Dental, and Long-Term Disability Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) Effective Date of New Election. Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that any replacement coverage commences later).

(c) Effect of New Election Upon Amount of Benefits. For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 9.4 respectively.

12.3 Events Permitting Exception to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

(b) Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below). A Participant may change his or her election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to

a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage.

(2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(3) Special Consistency Rule for DCAP Benefits. With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.

(e) HIPAA Special Enrollment Rights (Applies Only to Premium Payment Benefits for the Medical Insurance Plan). If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code §9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA, and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage, and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of Section 12.3(e)(1), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Certain Judgments, Decrees, and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits). If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan, and such coverage is actually provided.

(g) Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits). If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits). For purposes of this Section 12.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will

automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) Limitation on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions (Sections 12.3(h)(1) through 12.3(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(d)(2)(A) through (G), incorporating the rules of Code §§152(f)(1) and 152(f)(4).

(i) Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).

The definition of "similar coverage" under Section 12.3(h) applies also to this Section 12.3(i).

(1) Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan)

coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) Definition of Loss of Coverage. For purposes of this Section 12.3(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(d) DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria

plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(j) Reduction of Hours (Applies Only to Premium Payment Benefits for the Medical Insurance Plan). A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Insurance Plan coverage is revoked.

A Participant entitled to change an election as described in this Section 12.3 must do so in accordance with the procedures described in Section 12.2.

12.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for benefits under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedures set forth in the Nebraska State College System Health and Welfare Plan. The Benefits Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Medical, Vision, Dental, and Long-Term Disability Insurance Benefits

Claims and reimbursement for Medical, Vision, Dental, and Long-Term Disability Insurance Benefits shall be administered in accordance with the claims procedures for the Medical, Vision, Dental, and Long-Term Disability Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Medical, Vision, Dental, and Long-Term Disability Insurance Plans.

13.3 Claims Deadline

Unless otherwise provided herein or required pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Employee or his or her designee to make sure this requirement is met.

13.4 Limitations Period for Filing Suit

Unless otherwise provided herein or required pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedure.

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Benefits Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.8 Inability to Locate Payee

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 following a reasonable time after the date any such payment first became due.

14.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

EXHIBIT C

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 9.6 with respect to DCAP Benefits, and then by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan (including any Component) at any time for any reason by resolution of the Employer's Board of Trustees or by any person or persons authorized by the Board of Trustees to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Nebraska, to the extent not superseded by the Code or any other federal law.

15.5 Compliance With Code and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

15.6 No Guarantee of Tax Consequences

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

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.10 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

This document is executed this _____ day of _____, 2019.

Board of Trustees, Nebraska State Colleges

By:_____

Name:_____

Title:_____

EXHIBIT C

APPENDIX A

Related Employers That Have Adopted This Plan, With the Approval of the Board of Trustees of the Nebraska State Colleges:

Chadron State College

Peru State College

Wayne State College

System Office

EXHIBIT C

APPENDIX B

Exclusions–Medical Expenses That Are Not Reimbursable From the Health FSA

The Nebraska State Colleges Medical Reimbursement Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA–that is, expenses that are not reimbursable, even if they meet the definition of "medical care" under Code §213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

Exclusions: The following expenses are not reimbursable from the Health FSA, even if they meet the definition of "medical care" under Code §213(d) and may otherwise be reimbursable under legal requirements applicable to health FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Medicines or drugs (other than insulin) available over-the-counter that have not been prescribed.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.

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- Transportation expenses of any kind, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code §213(d).
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. §1.125-5(k)(4) or other applicable law or regulations.