Flexible Spending Account (FSA)

Employer Salary Reduction Plan Summary Plan Description (SPD)

Introduction

Introduction

Your Employer sponsors the Employer Salary Reduction Plan (as defined below) (the Plan) that allows eligible Employees to choose among different benefits and pay for those benefits with pre-tax dollars.

Within this SPD you will find a lot of information about the Plan, but it may not answer every question that could come up. Your Employer maintains a separate plan document and related compliance documentation that may be available for your review.

SECTION I: Plan Information

Employer / Plan Sponsor	• Entity Name: Texas Wesleyan University • Address: 1201 Wesleyan St, Texas Wesleyan University, Fort Worth, TX 76105 If a plan is being presented by a group of employers, it may be the organization, association, or committee responsible for the plan.
Plan Administrator	• Entity Name: Texas Wesleyan University • Address: 1201 Wesleyan St, Texas Wesleyan University, Fort Worth, TX 76105 • Attention: Genaro Martinez • Telephone Number: 817-531-5853 The Employer is the Administrator and the named fiduciary for the group health plan and FSA for purposes of ERISA §402(a).
The Named Fiduciary for the Plan	• Kim Stergio The named fiduciary is the individual person or persons with the authority to control and manage the operation of the plan. *(Usually someone in Benefits).*
Agent for Service of Process	• Megan Cooley The *agent for service of legal process* is the person designated by a business entity, such as a corporation, to receive legal correspondence on behalf of the business entity within the state which the agent's address is located. The person may be an officer of the corporation or a third party, such as the corporation's lawyer. If a company has not designated such a person or entity, it is the person or people with the authority to accept legal process on behalf of the company. *(Usually someone very Senior that can speak on behalf of the company).*

EIN	75-0800691
Governing State	TX
Plan Number	502
The Plan Name	Employer Salary Reduction Plan Welfare plan providing some or all of: • Medical, Dental, and/or Vision Insurance • Health FSA: General Purpose FSA benefits • Health FSA: Limited Purpose FSA benefits • Dependent Care FSA benefits
Open Enrollment Period	The period during which you have an opportunity to elect participation in the Plan by signing and returning an individual Election Record. You will be notified of the timing and duration of the Open Enrollment Period, which for a Plan Year generally will be the month before the Plan Year Begins. Please check your open enrollment materials.
Effective Date	04/01/2026
Plan Year	04/01-03/31

SECTION II: Medical, Dental, and/or Vision Insurance

This **Premium Only Plan ("POP")** is adopted for the purpose of providing employees with the opportunity to pay their medical, dental, and/or vision insurance premiums with pre-tax dollars, in accordance with the requirements of Section 125 of the Internal Revenue Code (IRC), thereby reducing their taxable income and resulting in potential tax savings.	
Election	Elections may be made for the following Premium Payment Component and you can pay premiums for the following insurance plans with pre-tax dollars: • Medical Insurance • Dental Insurance • Vision Insurance
Description	The Premium Only Plan allows eligible employees to pay premiums for their group health, dental, and/or vision insurance premiums before taxes are applied. This means the amount you pay for your premiums will be deducted from your paycheck on a pre-tax basis, reducing your overall taxable income.
Eligibility	You are eligible to participate in the POP if:

	• You satisfy the eligibility requirements of the Employer's group health/medical plan, thereby becoming an Eligible Employee, and thus becoming eligible to participate in the Plan.
Employee Contributions & Salary Reductions	When you enroll in the Employer's group medical, dental, and/or vision insurance plan, your share of the plan(s) premiums, if any, will be automatically deducted from your paycheck before taxes are calculated. This means the money for your premiums will be taken out before your federal income tax, Social Security, and Medicare taxes are applied, which reduces your taxable income. The amount you contribute to the POP will be based on the premiums for the medical, dental, and/or vision insurance plans and will be deducted from your pay before federal income taxes, Social Security taxes, and Medicare taxes are calculated, reducing the employee's taxable income. These deductions will not reduce the employee's wages for purposes of state and local taxes, unless required by applicable state law. Your contribution amounts will depend on the benefits you select during open enrollment or your initial eligibility period.
Tax Information	These contributions will **not** reduce your state income tax (unless required by state law). Your pre-tax contributions may also affect your eligibility for other tax benefits, such as Social Security benefits or tax deductions, so please consult with a tax advisor if you have specific questions.
Claims	The applicable insurer will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurer for a review of the denied claim. For more information about how to file a claim and for details regarding the medical, dental, and/or vision insurers' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Medical, Dental and/or Vision Insurance Plan.
Legal & Compliance	Medical, Dental and/or Vision insurance are group health plans governed by ERISA.

More Information	For more information about the Premium Only Plan, including how to enroll, modify your elections, or general questions about your insurance premiums, please contact the **Human Resources** department.

SECTION III: Health Flexible Spending Account and Dependent Care Flexible Spending Account

	General Purpose Flexible Spending Account (GPFSA)	**Limited Purpose Flexible Spending Account (LPFSA)**
Election	The Health FSA election may be for General Purpose Health FSA Coverage.	The Health FSA election may be for Limited (Vision/Dental/Preventive Care) Health FSA Coverage.
Description	Health Flexible Spending Arrangement (Health FSA) — permits Employees to pay for their qualifying Medical Care Expenses that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits. A Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere. If you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Record with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. The Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. If you elect Health FSA Benefits, a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to and the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is a recordkeeping account; it is not funded, all reimbursements are paid from the general assets of the Employer, and it does not bear interest. Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect an Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. If you elect a General Purpose Health FSA Coverage Option, your Spouse and your Dependents will also be ineligible to make HSA contributions.	

Eligible Expenses	For purposes of the General Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d). For more information about what items are—and are not—Medical Care Expenses, you may refer to IRS Publication 502 (Medical and Dental Expenses). In general, you should consult legal and tax specialists to better understand your compliance obligations. You may not make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses Medical Care Expenses as described under the General-Purpose Health FSA Option.	You may not make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses Medical Care Expenses as described under the General-Purpose Health FSA Option. You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to Medical Care Expenses for: Services or treatments for dental care (excluding premiums); Services or treatments for vision care (excluding premiums); or Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code §223(c)(2)(C). Preventive care does not include services or treatments that treat an existing condition.
Funding Medium	The Health FSA is a group health plan governed by ERISA. Each FSA is self-funded. A third-party administrator processes claims for these Components based on direction from the Employer, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration of the FSA. There is no trust for any part of the Plan.	
Funds Availability	The full amount of Health FSA coverage that you have elected, reduced by prior reimbursements made during the same Plan Year, will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim so long as you have continued to pay the contributions. In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any. Note that only reasonable quantities of prescribed over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code §213(d) and have been prescribed.	
Maximum	• The maximum amount per Plan Year as adjusted for any increases	

FSA Benefits for Plan Year	announced by the IRS prior to the effective date of the plan year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen. You must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).
Minimum Election	There is no minimum election for the plan.
Employer Contributions	If you select one or more of the above benefits, you will pay all or some of the contributions; The Employer may contribute the following amount to your Health FSA per plan year: • The Employer makes *no* contributions
Carryover	• $680 or the maximum carryover amount allowed per Plan Year as adjusted for any increases announced by the IRS prior to the effective date of the plan year. You may carry over up to the amount specified of unused funds remaining in the FSA at the end of the Plan Year to be used for eligible expenses incurred during the next Plan Year. Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the FSA. If you are otherwise eligible for the Health FSA for a Plan Year but you do not make a Health FSA election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year Medical Care Expenses (in accordance with Plan terms). However, you must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the carryover and elect the FSA in the next plan year. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.
Grace Period	No Grace period permitted
Runout	• 90-day runout for end of plan year and terminated employees The number of days you will have after the end of the Plan Year or after you cease to be eligible as a participant in which to submit a claim for reimbursement incurred during the Plan Year. Grace periods run concurrent to runout, if both are applicable.
Claim	When you incur an expense that is eligible for payment, you must submit a

Procedures	claim to the Plan Administrator. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses. Typically, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. For medicines or drugs, you must provide an EOB, prescription, or receipt with an Rx number and the name of the purchaser or patient. If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Record for a valid claim. Claims will be paid in the order in which they are approved, up to the amount you have elected for the Plan Year. You will be notified in writing if any claim for benefits is denied. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source. Some expenses may be validated at the time the expense is incurred if an electronic card payment method is utilized. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented. Approved claims will be reimbursed directly to the eligible employee via direct deposit to the linked bank account. No cash, check, or other forms of reimbursement are supported.
Continuation Coverage	For purposes of pre-taxing COBRA (if this applies to you) coverage for Health FSA Benefits, certain Employees may be able to continue eligibility in the Plan for a certain period. *COBRA*. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." See Attachment 2 (found at the end of this Summary) regarding COBRA coverage under the Health FSA Component, including when it may become available to you and your family and what you need to do to protect the right to receive it. See the booklets for the Medical, Dental, and/or Vision Insurance Plans for information about COBRA continuation coverage under those plans. Note also that for purposes of pre-taxing COBRA coverage, certain Employees may be able to continue eligibility in the Plan for certain periods—see Attachment 1 (found at the end of this Summary). *USERRA*. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.
COBRA	COBRA is a federal law that gives certain employees, spouses, and

	dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HDHC Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HDHC Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events: • Your termination from employment or reduction of hours; • Your divorce or legal separation from your Spouse; • Your becoming eligible to receive Medicare benefits; • Your Dependent child ceasing to qualify as a Dependent. If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.
Other	*Qualified Medical Child Support Order* - The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator *HEART Act Distributions for Qualified Reservists* - Certain participants meeting legal eligibility requirements may take Qualified Reservist Distributions from their Health FSA under the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act). The Plan will be administered pursuant to the HEART Act (as amended) and will permit reservists called or ordered to active duty for a period of at least 180 days (or indefinitely) to take certain distributions after the call/order and before the last day that reimbursements could be made during the plan year of the call/order. The Plan must receive a copy of the qualifying call/order prior to the distribution being made. The amount available will be the participant's elected Health FSA amount minus reimbursements made to participant, including qualifying claims incurred prior to the distribution, but requested after the distribution has been requested and before it has been made.

HSA Eligibility	If you elect General-Purpose Health FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect a Limited Health FSA Coverage Option. In the event that an expense is eligible for reimbursement under both a Limited Purpose FSA and an HSA, you may seek reimbursement from either a Limited Purpose FSA or an HSA, but not both.

Dependent Care Flexible Spending Account (DCFSA)	
Description	*Dependent Care Flexible Spending Account (DCFSA)*— also sometimes called dependent care assistance program (DCAP)—permits Employees to pay for thei qualifying Dependent Care Expenses with pre-tax dollars. A DCFSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere. If you elect DCFSA Benefits, then you will be able to provide a source of pre- tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an ElectionRecord with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes. If you elect DCFSA Benefits, a "DCFSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, and the contributions for such benefits that you have paid during the Plan Year. Your DCFSA Account is a recordkeeping account; it is not funded, all reimbursements are paid from the general assets of the Employer, and it does not bear interest.
Eligible Expenses	Dependent Care Expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement: Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be: — a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild, foster child, sibling or step siblings, or a descendant of one of them; and (3) not provide more than half of their own support for the year); — your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or — a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a

	tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition). Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the child as a dependent. The expenses are incurred for services rendered after the date of your election to receive DCFSA Benefits and during the Plan Year to which the election applies. The expenses are incurred to enable you to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day. The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual. If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household. If the expenses are incurred for services provided by a dependent care center—that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis—the center must comply with all applicable state and local laws. The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person whom you (or your Spouse) can claim as a dependent for federal income tax purposes. If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred. The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight. The expenses can be for any of the following (assuming that the other requirements for reimbursement are met): — expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care); — the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and — expenses such as application fees, agency fees, and deposits that relate to

	but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided—e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement). Ask the Plan Administrator if you need further information about which expenses are—and are not —likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.
Funding Medium	DCFSA is not an ERISA welfare benefit plan under ERISA. Each FSA is self-funded. A third-party administrator processes claims for these Components based on direction from the Employer, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration of the FSA. There is no trust for any part of the Plan.
Funds Availability	You specify the amount of DCFSA Benefits that you wish to pay with your salary reduction during open enrollment. That portion is deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). These portions will be credited as of each pay period. The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCFSA Account at the time of the claim, reduced by the amount of any prior reimbursements paid to you during the Plan Year.
Maximum FSA Benefits for Plan Year	• The maximum Flexible Spending Account (FSA) contribution is determined in accordance with applicable IRS limits for the plan year. Contribution limits may vary based on tax filing status and are subject to change each year as announced by the IRS.
Minimum Election	There is no minimum election for the plan
Note on Dependent Care FSA Limit	Your statutory limit is the smallest of the following amounts: - Your earned income for the calendar year (after your salary reductions under the Plan); - The earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for more than one-half of such year), or (b) a full-time student); or - either $7,500 or $3,750 for the calendar year (or the maximum amount as adjusted for any increases announced by the IRS prior to the

	effective date of the plan year) , depending on your marital and tax filing status, as described further in "Maximum FSA Benefits for Plan Year".
Employer Contributions	The Employer makes no contributions to your DCFSA.
Carryover	Carryovers are not permitted under the DCFSA.
Grace Period	No grace period permitted
Runout	• 90-day runout for end of plan year and terminated employees The number of days you will have after the end of the Plan Year or after you cease to be eligible as a participant in which to submit a claim for reimbursement incurred during the Plan Year. Grace periods run concurrent to runout, if both are applicable.
Claim Procedures	When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCFSA Reimbursement Request Form. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses. If there are enough credits to your DCFSA Account, you will be reimbursed for your eligible DCFSA Expenses within 30 days after the date you submitted the DCFSA Reimbursement Request Form. If a claim is for an amount larger than that remaining in your current DCFSA Account balance, then you will be reimbursed for the amount of contributions made and you will need to submit another claim as additional payroll contributions are made into the account. You cannot be reimbursed for any total expenses above your available annual credits to your DCFSA Account.
Other	You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCFSA, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. Consult a tax advisor to determine the appropriate tax treatment of your specific circumstances. You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCFSA, the maximum amount that you and your Spouse together can exclude from income is limited to the applicable IRS threshold for the plan year. This limit may be adjusted periodically and is subject to change as announced by the IRS. No reimbursement will be made to the extent that such reimbursement would

	exceed the balance in your DCFSA Account.
COBRA	Not applicable
HSA Eligibility	You can elect a Dependent Care FSA and also elect HSA Benefits.

Definition of an Employee

Employees who are eligible for the Premium Payment Benefits are eligible to participate in the respective Plans can enroll by following the election procedures described herein. An Employee is anyone whom the Employer classifies as such. Employees do not include (a) leased employees or individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as an employee; (b) individuals who perform services for the Employer but who are paid by a temporary, other employment, or staffing agency; or (c) self- employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Participation Start and End Date

After you satisfy the eligibility requirements, you become a Participant by completing your individual Election Record. The Election Record will be available during the Open Enrollment Period. You must complete the Election Record and return it to the Plan Administrator within the time period specified in the enrollment materials. Absent a Change in Election Event, an eligible Employee who fails to complete, confirm, and return an Election Record as required will not be able to elect any benefits under the Plan until the next Open Enrollment Period so long as the conditions for eligibility do not cease to be met.

A Participant continues to participate in the Plan until (a) termination of the Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

For purposes of COBRA (if this applies to you) coverage for Health FSA Benefits, Medical, Dental, and/or Vision Insurance coverage, if applicable, certain Employees may be able to continue eligibility in the Plan for a certain period.

Definition of Incurred Expense

Eligible expenses must have been incurred during that Plan Year. An expense is incurred when the service that causes the expense is provided, not when the expense was paid.

If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred.

You may not be reimbursed for any expenses incurred before the Plan became effective, before your Election Record became effective, or after a separation from service unless you are covered through valid continuation coverage. Expenses incurred during a subsequent Plan Year can only be reimbursed from your FSA Account for that Plan Year.

If there is a grace period, please see "Grace Period" for additional terms.

Claims Determination Procedure

Claims under the Medical, Dental and/or Vision Insurance Benefits. The applicable insurer will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurer for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a 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). For more information about how to file a claim and for details regarding the Medical, Dental, and/or Vision insurer's claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Medical, Dental, and/or Vision Insurance Plan.

Claims Under the FSA Plan. If a claim for reimbursement under the Plan is wholly or partially denied, or you are denied a benefit under the Plan due to an issue germane to your coverage under the Plan, then the claims procedure described below will apply.

If your claim is denied, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 30 days from receipt of the notice in which to provide the specified information. Failing to submit supplemental materials or to otherwise meet the requirements to substantiate the claim may result in such claim being denied.

Appeals Process under the FSA Plan

Appeals. If your claim under the Plan is denied, then you (or your authorized representative) may request review upon written notification to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal must state the reasons that you believe your claim should not have been denied. It should include any additional facts and/or documents that support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review documents and other information relevant to your appeal.

Decision on Review. Appeals under the Plan will be reviewed and decided by the Plan Administrator or another entity designated in the Plan in a reasonable time not later than 60 days after the Plan Administrator receives your request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth: the specific reason(s) for the decision on review; the specific Plan provision(s) on which the decision is based; a statement of your right to review relevant documents and other information; if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and, a statement of your right to bring suit under ERISA §502(a) (where applicable).

Claims Deadline. Unless otherwise provided under the Plan or required pursuant to applicable law, a claim for benefits under the Plan must be made within one year after the date the expense was incurred that gives rise to the claim. You (or your designee, if applicable) are responsible for making sure this requirement is met.

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

Tax Implications Under the Plan

You may save both federal income tax and FICA taxes by participating in the Plan, as well as state taxes where applicable, by reducing your gross income through pre-tax contributions to the Plan.

Generally, you will not be taxed on your FSA Benefits, up to the limits set by the IRS. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit.

Paying for Benefits on a Pretax Basis

An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by completing an Election Record/Salary Reduction Agreement (the "Election Record") with the Employer. The Election Record includes an agreement authorizing a salary reduction to pay for such employee's share of the cost of coverage with pre-tax funds. Subsequent payments are made by the same pre-tax salary reductions on a typically equal basis, except at the discretion of the Employer (typically to account for elections not perfectly divisible by the number of pay periods remaining in the plan year).

Fiduciary

The Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and Benefits. The Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Administrator may delegate some of its administrative duties to agents.

Forfeitures

You will forfeit any amounts in your FSA Account that are not applied to pay expenses submitted at the conclusion of the plan year or runout period, if applicable, following the end of the Plan Year for which the election was effective or carried over as permitted by this SPD.

Forfeited amounts will be used as follows:

First, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the FSA during the Plan Year and the subsequent Plan Year; 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 law or IRS guidance.

Administrative Costs under the Plan

The cost is paid in part by the use of forfeitures, if any. The rest of the cost of administering the Plan is paid entirely by the Employer.

Qualifying Life Events

This plan is subject to the definition of a qualifying life event as defined in Sec 125 (26 CFR 1.125-4).

Election Changes During the Plan Year

You generally cannot change your election to participate in the Plan or vary the salary reduction amounts that you have selected during the Plan Year unless an exception applies. See the various Change in Election Events that are described in Attachment 1 for more information about exceptions.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code, if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding any amounts due from your compensation.

Employment Termination or Changes to Eligibility during the Plan Year

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan. To the extent that a continuation right applies, please consult the COBRA information herein for more information.

If you are rehired within the same Plan Year and are eligible for the Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described above before again becoming eligible to participate in the Plan.

Amendment and Termination

Although the Employer intends to continue the Plan indefinitely, the Employer reserves the

right to amend or terminate the Plan at any time and for any reason. If either of these actions is taken, you will be notified.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Leave of Absences

FMLA Leaves of Absence or other Benefits Protective Leave. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your benefits, as applicable, on the same terms and conditions as if you were still active. Your Employer may require you to continue all Medical and Dental Insurance Benefits and Health FSA Benefits coverage, as applicable, while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your benefits, as applicable, then you may pay your share of the contributions: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by prepaying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation; or (c) by other arrangements agreed upon by you and the Plan Administrator.

If your Employer requires all Participants to continue benefits, as applicable, during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health FSA Benefits, as applicable, coverage ceases while you are on FMLA leave (e.g., for nonpayment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence,

with regard to Health FSA Benefits and/or DCFSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit and/or DCFSA 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 you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits and/or DCFSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you, if not otherwise paid by your regular salary reductions, will be prepaid before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

Your Rights *[Health FSA & Group Health Plans]*

As a participant in the plan, you are entitled to certain rights and protections under the ERISA, which provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in

which case the Employer, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

If this is applicable to you, continue your Medical and Dental Insurance Plan coverage (and, in some cases, your Health FSA 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 and may be subject to a 2% premium in addition to the cost of the coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Employer, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have

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

HIPAA Privacy Rights

Under HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer.

Attachment 1

When Can I Change Elections Under the Plan During the Plan Year?

Health Flexible Spending Account (FSA) elections are locked in for the entire plan year and cannot be changed once they are made. Dependent Care FSA (DCFSA) elections may be changed during the plan year only if you experience a qualifying life event and the requested change is consistent with that event.

For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Special Enrollment Rights. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Record within 30 days after the occurrence. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical or Dental Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

Leaves of Absence *(Applies to Health FSA and DCFSA Benefits, as applicable).* You may change an election under the Plan upon FMLA and non- FMLA leave only as described in "Leave of Absence" in the table above.

Change in Status *(Applies to Health FSA Benefits (as limited below) and DCFSA Benefits, as applicable).* If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change

in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or

Change in Status—Other Requirements *(Applies to Health FSA Benefits (as limited below) and DCFSA Benefits, as applicable).* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with such Change. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. A desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCFSA Benefits, as applicable, the event may also affect eligibility of Dependent Care Expenses for the dependent care tax exclusion).

You must satisfy the following specific requirements in order to alter your election based on that Change in Status:

Loss of Dependent Eligibility; Special COBRA Rules. For accident and health benefits (here, the Medical and Dental Insurance Plans and Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving the death of your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See the Plan Administrator for more information.

Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in

Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

DCFSA Benefits (as applicable). With respect to the DCFSA Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCFSA; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Attachment 2

COBRA Continuation Coverage Rights Under the Health FSA Component Introduction

The following paragraphs generally explain COBRA coverage under the Health FSA Component, when it may become available to you and your family, and what you need to do to protect the right to receive it. The description of COBRA coverage contained in this Attachment applies only to the Health FSA Component of the Plan and not to any other benefits offered under the Plan or by the Employer.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You may have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

COBRA Coverage May Become Available to "Qualified Beneficiaries." After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

COBRA Coverage Under the Health FSA Component

COBRA Coverage Is Offered Only in Limited Circumstances. COBRA coverage under the Health FSA Component will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year; Carryover Rights, If applicable. Participants with underspent accounts can receive Health FSA COBRA coverage only through the end of the plan year in which the COBRA qualifying event occurs. However, qualified beneficiaries who continue COBRA coverage through December 31 of that plan year may carry over up to $610 (or the maximum amount as adjusted for any increases announced by the IRS prior to the effective date of the plan year) of unused Health FSA amounts remaining at the end of that plan year in accordance with the Plan's provisions regarding Health FSA carryovers, until the end of the 18-, 29-, or 36-month maximum COBRA coverage period that applies under the Medical and Dental Insurance Plans or until the amounts are used up, if earlier.

All Qualified Beneficiaries Are Covered Together Under the Health FSA Unless Otherwise Elected. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Employer for more information.

No Health FSA Open Enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying Events for the Covered Employee. If you are an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because either one of the following qualifying events happens: (a) your hours of employment are reduced; or (b)your employment ends for any reason other than your gross misconduct.

Qualifying Events for the Covered Spouse. If you are the spouse of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens: your spouse dies; your spouse's hours of employment

are reduced; your spouse's employment ends for any reason other than gross misconduct; or you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your coverage under the Health FSA Component in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens: your parent-employee dies; your parent-employee's hours of employment are reduced; your parent-employee's employment ends for any reason other than gross misconduct; or you stop being eligible for coverage under the Plan as a Dependent.

Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA). Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Health FSA Component during the leave. Contact the Employer for more information about these special rules.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage under the Health FSA Component to qualified beneficiaries. You need not notify the Employer of any of these qualifying events.

You Must Notify the Plan Administrator of Certain Qualifying Events by This Deadline. **For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.**

No COBRA Election Will Be Available Unless You Follow the Notice Procedures and Meet the Notice Deadline. **You must use the Plan's Form entitled "Notice of Qualifying Event Form." If these procedures are not followed or if the notice is not provided to the Employer during the notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Electing COBRA Coverage

How to Elect COBRA. **To elect COBRA, you must complete the Election Record that is part of the Plan's COBRA election notice and mail or hand-deliver it to the Employer.** (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Record from the Employer.) You may provide the Election Record only

by mail or hand-delivery. Delivery by another method, including by fax or email, is not acceptable.

Deadline for COBRA Election. **If mailed, your election must be postmarked (or if hand-delivered, your election must be received) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION RECORD BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Independent Election Rights. Each qualified beneficiary will have an independent right to elect COBRA. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE.**

Length of COBRA Coverage

COBRA coverage under the Health FSA Component is temporary and can last only until the end of the plan year in which the qualifying event occurred.

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

COBRA coverage under the Health FSA Component will automatically terminate before the end of the maximum period if any required premium is not paid in full on time or the employer ceases to provide any group health plan for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the Plan (including both employee and any employer contributions but disregarding any carryovers, if applicable, from the previous plan year) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

Payment for COBRA Coverage

How Premium Payments Must Be Made. Unless you are able to continue eligibility in the Plan and pay your COBRA premiums on a pre-tax basis as described in Attachment 1, all COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice

provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When Premium Payments Are Considered to Be Made. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage. If you elect COBRA, you do not have to send any payment with the Election Record. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Record is postmarked, if mailed, or the date your Election Record is received by the individual at the address specified for delivery of the Election Record, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided below to confirm the correct amount of your first payment.

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

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly Payments for COBRA Coverage. After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these coverage periods (that is, **we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time**).

Grace Periods, if applicable, for Monthly COBRA Premium Payments. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be

provided for each month so long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for reimbursement of a medical expense incurred while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption With the Covered Employee During a Period of COBRA Coverage. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee.

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

Notice Procedures

Warning

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from the Employer without charge). Oral notice, including notice by telephone, is not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to: Texas Wesleyan University HR. However, if a different address for notices to the Plan appears in the Plan's most recent SPD, you must mail or hand-deliver your notice to that address. You may provide a notice only by mailing or hand-delivery.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period.

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (Employer Salary Reduction Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/beneficiaries who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Donna S. Nance Digitally signed by Donna S. Nance Date: 2026.07.19 15:03:14 -05'00'
Name

Texas Wesleyan University
Employer

July 19, 2026
Date