SANTA CLARA UNIVERSITY

SECTION 125 CAFETERIA PLAN

Summary Plan Description

January 1, 2024

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PLAN INFORMATION

This Summary Plan Description ("SPD") outlines your rights and responsibilities under the Santa Clara University Section 125 Cafeteria Plan ("Plan") and reflects the Plan's benefits ("Elective Benefits") as of January 1, 2024, which may change from time to time.

For purposes of the Health FSA, this document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions ("Benefit Documents"), constitutes this Plan's Summary Plan Description ("SPD"). You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Elective Benefit.

Plan Name:	Santa Clara University Section 125 Cafeteria Plan, a component plan of the Santa Clara University Health and Welfare Plan
Type of Plan:	The Plan is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code ("Code"). It includes a Code Section 105 Health Care Expense Account ("Health FSA"), classified by the Department of Labor ("DOL") as a "welfare" plan, and a Code Section 129 Dependent Care Expense Account ("Dependent Care FSA"). The Health FSA portion of this Plan also is subject to the Employee Retirement Income Security Act of 1974 ("ERISA")
Plan Year:	January 1 through December 31 of the same calendar year
Plan Number:	501
Effective Date of this SPD:	January 1, 2024
Original Effective Date of Plan:	November 1, 1988
Source of Contributions:	From Santa Clara University's general assets and employee contributions, when required by Santa Clara University in its sole discretion
Plan Sponsor and Plan Administrator:	President & Board of Trustees of Santa Clara College dba Santa Clara University 500 El Camino Real Santa Clara, CA 95053 408-554-4932
Plan Sponsor's Federal Employer Identification Number:	94-1156617
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Health FSA Claims Administrator:	WEX Health PO Box 2926 Fargo, ND 58108-2926 866-451-3399 www.wexinc.com

For additional information regarding the Plan, contact Santa Clara University's Director of Employee Development and Wellness at 408-554-4932 or smmata@scu.edu. Copies of applicable Benefit Documents are available from Santa Clara University on request.

ENROLL TO STRETCH YOUR BENEFIT DOLLARS

Establishment and Purpose

President & Board of Trustees of Santa Clara College dba Santa Clara University ("Santa Clara University") maintains the Santa Clara University Section 125 Cafeteria Plan ("Plan") for the exclusive benefit of its eligible employees and the employees of its Affiliated Organizations. The Plan allows you to save money by giving you the opportunity to use pre-tax dollars:

- To pay your share of the cost for coverage under Santa Clara University's group health and welfare plan ("Benefit Plans") on a pre-tax or after-tax basis through payroll deductions; and,
- To set-aside pre-tax dollars to pay for qualified health care and dependent care expenses.

Advantages of Pre-Tax Contributions

Participation in any of the Elective Benefits under the Plan is a way to stretch your paycheck by increasing your take-home pay. The best way to understand how this works is through an example:

Married w/ One Child	Non-Participant	Participating in the Plan
Gross Income	$60,000	$60,000
Pretax Benefits Cost	N/A	$5,700
Adjusted Gross Income	$60,000	$54,300
Standard Deduction	($25,100)	($25,100)
Taxable Income	**$34,900**	**$28,400**
Federal Income Tax	($3,829)	($3,145)
FICA Tax	($3,720)	($3,366)
After-Tax Contributions	($5,700)	N/A
Spendable Income	**$46,751**	**$47,789**
Take Home Pay Difference:		**$1,038**

As you can see, the Plan's before-tax contributions will reduce your taxable income and increase your spendable income (by $1,038 in the above example). In addition, depending on where you live, your state income taxes may be lower.

Account Options

Under the Plan, you can enroll in any of the following Elective Benefits or elect to waive participation in all of them.

- Premium Contribution Plan ("Premium Contribution Benefits") that allows you to pay your share of premium contributions for the Benefit Plans listed on Appendix B on a pre-tax or after-tax basis.
- Health Care Expense Account ("Health FSA") that reimburses you for a wide variety of health care costs not covered by your Benefit Plans. You may elect coverage under either a General-Purpose or a Limited-Purpose Health FSA, but not both (see the "Health FSA Benefits" section for details.
- Dependent Care Expense Account ("Dependent Care FSA") that reimburses you for the cost of eligible work-related dependent care expenses.
- Health Savings Account ("HSA") for employees covered under the Plan's high deductible health plan ("HDHP") that reimburses you for a wide variety of health care costs not covered by your Benefit Plans.

Use or Lose Rule

It's important to remember that you must use the full amounts you deposit into the Health FSA (in excess of the permissible carryover amount) and Dependent Care FSA accounts to pay for eligible expenses incurred during the Plan Year, or you will forfeit any remaining balance. In addition, you have until 90 days following the end of a Plan Year to submit your claims.

Please Note: You cannot convert unused funds to cash or transfer the funds from one Elective Benefit to another, so it's important to estimate your expenses carefully!

Salary Reduction Agreement

An employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into a Salary Reduction Agreement with Santa Clara University. Under that Salary Reduction Agreement, you agree to a salary reduction to pay for your share of the cost of Plan coverage instead of receiving a corresponding amount of

your regular pay that would otherwise be subject to taxes. For the rest of the Plan Year, you must pay contributions for such coverage by having that portion deducted from each paycheck (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Pre-Tax Benefit Considerations

Social Security and Unemployment Insurance Benefits. Because your contributions are made on a pre-tax basis, they lower the earnings on which your Social Security taxes are based. This means your future Social Security earnings may be reduced. Your pre-tax contributions may also reduce the earnings used to calculate your unemployment insurance benefits.

Highly Compensated Employees. Certain highly paid employees may have their elections reduced in order for the Plan to comply with applicable federal laws prohibiting discrimination. If this applies to you, you will be notified.

ENROLLMENT AND PARTICIPATION

Eligibility

The Plan is available to any individual who meets the Plan participation requirements specified in Appendix A and whose relationship with Santa Clara University is, under common law, that of an employee.

Eligible Dependents

In general, the definition of eligible dependents is the same definition used under the particular Benefit Plan in which you are enrolled and who qualifies for exclusion from your income for federal tax purposes. This means, for example, that the Health FSA can reimburse the otherwise eligible health care expenses of a participant's legally married spouse, children who are under age 27 as of the end of the taxable year, and any other individuals who qualify as a participant's tax dependents for health coverage purposes. Santa Clara University may impose additional restrictions that shall be described in your enrollment materials.

Note that the definition of "dependent" for purposes of the Dependent Care FSA is detailed in the "Dependent Care FSA" section.

Please familiarize yourself with the above definitions before attempting to estimate your contributions to the Plan.

Proof of Dependent Eligibility

You may be required to provide proof of your covered dependents' eligibility upon request. If you fail to timely provide the requested documentation, your dependent may lose coverage under the Plan whether or not he or she is otherwise eligible to participate. A dependent whose coverage is terminated due to lack of or insufficient documentation will not be eligible for COBRA coverage.

Qualified Medical Child Support Orders

Health FSAs that qualify as group health plans may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child. You may obtain a copy of Santa Clara University's procedures governing QMCSO determinations, free of charge, by contacting the Human Resources Department.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that Santa Clara University determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Enrollment Procedures

If you are eligible for Plan benefits, you will receive enrollment materials with information about the Elective Benefits available to you, the cost for each benefit choice, and instructions for completing your elections in a timely manner. Generally you must submit the completed election form (or any electronic enrollment materials) *prior* to your coverage date. The benefits you enroll in will take effect once you meet any applicable waiting periods or other requirements.

By completing the enrollment process, you authorize Santa Clara University to withhold, from your paycheck, the cost of the benefits you have selected. The amounts withheld from your pay for each pay period will be shown on your paycheck stub.

Failure to Enroll When First Eligible. If you do not enroll in any Elective Benefits when you first become eligible (either because you waive coverage or you fail to submit an election form within the required timeframe), you will not have an opportunity to elect coverage again until the next Plan Year (January 1 through December 31) unless you experience one of the "Qualifying Life Events" described in the Permissible Election Changes section below.

Default or Negative Coverage. Consistent with federal regulations, Santa Clara University at its discretion, may automatically enroll newly eligible employees in certain benefits for the remainder of their first Plan Year. In the event Santa Clara University adopts such enrollment procedures, it will provide you with the opportunity to modify the default elections or to entirely waive participation in the Plan.

Annual Open Enrollment

The Plan's Plan Year runs from January 1 to December 31 of the same calendar year. New enrollment materials will be provided to you during the annual Open Enrollment period held prior to the beginning of each Plan Year. If you are already enrolled in the Plan and decide you want to keep or modify your benefit choices, or waive participation, you generally must make your election changes ***prior*** to the beginning of the Coverage Period by following the annual enrollment procedures adopted by Santa Clara University.

If you are not covered under the Plan and fail to complete an election form during the next Open Enrollment period, your waiver of participation will continue for subsequent Plan Years until a timely election form is received by Santa Clara University (during an Open Enrollment period or after experiencing a Qualifying Life Event) as described below.

Once you enroll in the Plan, you will need to complete a new election form for each subsequent Plan Year to continue Plan participation. If you fail to complete the required election form in a timely manner, your coverage under the Plan will cease for the remainder of the next Plan Year.

Special Rules for the HSA Benefit

If you participate in the HSA Benefit, the amount you elect to set-aside in the HSA will not change each year unless you submit a request to increase, decrease or cancel your current contributions. However, if you later decide to dis-enroll from Santa Clara University's HDHP plan, your HSA payroll deductions will cease as of the date you are no longer covered by the HDHP plan.

Irrevocability of Elections

Except for the Qualifying Life Events described in the Permissible Election Changes section below, you generally cannot change your benefit elections for the duration of the coverage period or Plan Year with regard to participation in the Plan, salary reduction amounts, and elections of particular Benefit Options.

In addition, if you do not enroll in the Plan when first eligible (either because you waive coverage or fail to submit your election materials within the required timeframe), you will not have an opportunity to elect coverage again until the next Plan Year unless you experience a Qualifying Life Event.

Permissible Election Changes

Certain changes to your family or employment status ("Qualifying Life Event") may allow you a new 30-day window during which you may change your elections. The changes you make to your participation in the Plan must be made on account of, and consistent with, the change(s) in your family or employment status. In general, you cannot make changes retroactively. And if you stop participating, you can't be reimbursed for expenses incurred after the coverage end date.

See the "Permissible Election Changes" Section of this SPD for a list of permissible Qualifying Life Events. To make a change, contact Santa Clara University's Director of Employee Development and Wellness at 408-554-4932 to request the required change-in-enrollment materials.

Cessation of Participation

Unless otherwise stated in the applicable Benefit Documents your coverage will cease upon the earliest of the following:

- The date or end of the month in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment, or it may result because you average less than 130 hours of service per month during a Standard Measurement Period and are not eligible for benefits during the Standard Stability Period;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Employees on Military Leave" section; or,
- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of contributions by Santa Clara University.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) may have the right to continue health coverage temporarily under COBRA. See the "Continuation Coverage Rights" Section of this SPD for additional details.

PERMISSIBLE ELECTION CHANGES

You generally cannot change your pre-tax benefit elections under the Plan or vary the salary reduction amounts that you have selected during the Plan Year. However, you may revoke a benefit election (including, but not limited to, an election not to receive benefits under the Plan) after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year if both the revocation and new election are on account of and consistent with a Qualifying Life Event (as described below).

Election and salary reduction changes shall be effective on a prospective basis only (i.e., election changes will generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed), except that an election change on account of a HIPAA Special Enrollment Right, 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 back to the date of the qualifying event.

If you undergo a Qualifying Life Event, you must inform the Plan Administrator and complete the required change-in-coverage enrollment materials within 30 days after the occurrence of the Qualifying Life Event (or within 60 days in the case of a Special Enrollment Right due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage).

In the event of a conflict between the following provisions and the Internal Revenue Code ("IRC") Section 125 plan adopted by Santa Clara University, the IRC Section 125 plan shall control. The Plan Administrator reserves the right to determine whether an Employee has experienced a Qualifying Life Event and whether the Employee's requested election is consistent with such event.

Change of Status

Qualifying Life Events include a change of status due to one of the following events permitted under the rules and regulations adopted by the Department of the Treasury, but only if the Qualifying Life Event changes the individual's eligibility for the applicable benefit. These change in status rules apply to elections for all qualified benefits (e.g., accident or health coverage, group term life, Health FSA, Dependent Care FSA), except that election changes are generally not permitted for Health FSA or Dependent Care FSA benefits if the Qualifying Life Event is a change in residence:

- **Legal Marital Status**. Events that change an employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation, and annulment.
- **Number of Dependents**. Events that change the number of employee's dependents, including following birth, death, adoption, placement for adoption.
- **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or a change in worksite. In addition, if the eligibility conditions of this Plan or other employer-sponsored plan of the employee, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, change in student status, or any similar circumstance.
- **Residency Change**. A change in the place of residence of the employee, spouse, or dependent that results in a loss of eligibility for coverage (e.g. relocates outside the current plan's service area).
- **Qualifying Dependent**. For the Dependent Care Assistance Plan only, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a Qualifying Life Event.

HIPAA Special Enrollment Rights

An employee may change an election for group health coverage during a Plan Year and make a new election that corresponds with HIPAA Special Enrollment Rights, including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), as long as the employee meets the notice requirements. Special Enrollment Rights can occur when:

- You lose eligibility for coverage under a group health plan or other health insurance coverage (such as if you and your dependents lose coverage under your

spouse's plan) or if your employer terminates contributions toward health coverage.

- You gain a new dependent through marriage, birth, adoption, or being placed for adoption.
- You or your dependents lose coverage under a CHIP or Medicaid or become eligible to receive premium assistance under those programs for group health plan coverage.

ACA Marketplace/Exchange Enrollment

Qualifying Life Events include the opportunity to enroll in the ACA Marketplace/Exchange or other plans that offer minimum essential coverage under the ACA. These Qualifying Life Events apply to elections for group health plan coverage that is not Health FSA benefit coverage and that provides minimum essential coverage under the ACA:

- **ACA Marketplace/Exchange Election**. You may elect to cancel contributions for and payment of your portion of the group health plan premiums if (1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an ACA Marketplace or (2) you are seeking to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.
  In addition, effective January 1, 2024, you may prospectively drop some or all covered family members from the group health plan consistent with their enrollment or intended enrollment in an ACA Marketplace/Exchange.
- **ACA Reduction in Hours**. You may elect to cancel contribution for and payment of the employee-paid portion of group health plan premiums if (1) you had been reasonably expected to average at least 30 hours of service per week and subsequently move to a position in which you are reasonably expected to average less than 30 hours of service per week, even if you continue to be eligible under your employer-sponsored group health plan; and (2) your revocation of the election of coverage under the group health plan corresponds to your (and any dependents') intended enrollment in another plan that provides ACA minimum essential coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Change in Cost or Coverage

A change in cost or coverage, as follows, may allow an election change. The following Qualifying Life Events do not apply to the election of Health FSA benefits:

- **Change in Coverage under Another Employer's Plan**. You may make a new election if there is a change in coverage (for you, your spouse or your dependent) under a plan provided by another employer. Your new election must be on account of the change in the other employer's plan and correspond with that change. Among other things, this rule permits you to make election changes during another plan's open enrollment period.
- **Significant Coverage Decrease with or without Loss of Coverage**. If your coverage under a benefit is significantly curtailed or ceases during a Plan Year, you may revoke your election of such benefit and, in its place, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- **Significant Improvement or Addition of a New Benefit**. If, during the period of your coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, if you are not participating in the Plan when these options are added or changed, you may opt to become a participant and elect the new or newly improved benefit package option.
- **Significant Cost Increase**. If the cost of one of your benefit options increases significantly, you may either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.
- **Significant Cost Decrease**. If the cost of your benefit option decreases significantly, you may make corresponding changes in your payments. In addition, if you are not enrolled in the Plan and the cost of an option decreases significantly, you may elect coverage under the corresponding benefit package.
- In addition, if the expenses for a Component Plan increase or decrease during a Plan Year, the Plan may automatically increase or decrease accordingly your

required periodic contribution for such health insurance benefits.

Other Situations

Other situations that may permit an election change:

- **Court Order**. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) that requires accident or health coverage for an employee's child or for a foster child who is a dependent of the employee. The employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.
- **Entitlement to Medicare or Medicaid**. If an employee or an employee's spouse or dependent who is enrolled in an employer-sponsored accident or health plan becomes enrolled under Part A or Part B of Medicare or under Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), the employee may make an election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident or health Component Plan. In addition, if an employee or an employee's spouse or dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may make an election to commence or increase his or her coverage or the coverage of his or her spouse or dependent, as applicable, under Santa Clara University's accident or health plan.
- **Loss of Coverage under Health Plan of a Governmental or Educational Institution**. If an employee or an employee's spouse or dependent is enrolled in a group health coverage sponsored by a governmental or educational institution and loses such coverage, the employee may make an election change to add coverage under a corresponding Santa Clara University plan. Group health coverage sponsored by a governmental or educational institution includes (but is not limited to) coverage under: a state children's health insurance program (SCHIP); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; and a foreign government group health plan.
- **FMLA Leaves of Absence**. A participant may revoke coverage or, if coverage is required, continue coverage but delay payment of his or her share of the cost for group health plan coverage during the period of a leave of absence under FMLA. An employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.
- **COBRA Premiums**. If the employee or the employee's spouse or dependent becomes eligible for continuation coverage under an employer's group health plan as provided in Code section 4980B or any similar state law, the employee may elect to increase contributions under the Plan in order to pay for the continuation coverage.
- **Correcting Discrimination Issues under the Code**. If Santa Clara University determines before or during a Plan Year that the Plan or one of its Component Plans will fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, Santa Clara University may decrease or revoke the elections of affected highly compensated or key employees to ensure compliance with such nondiscrimination requirements or benefit limitation.

COVERAGE DURING A LEAVE OF ABSENCE

You may be eligible to continue certain Plan benefits for yourself and your covered dependents for a period of time during a leave of absence, subject to the leave policies and procedures adopted by Santa Clara University and to the extent prescribed by law. The type of leave you take determines the cost of your benefits (i.e., whether you can continue to pay the same contribution amounts toward your coverage or will need to pay the full premium cost). If you elect not to continue your benefits during your approved leave of absence or if you fail to timely pay for your benefits, your benefits may terminate for the duration of your leave.

Please refer to Santa Clara University's leave policies and procedures and the applicable Benefit Documents for a description of the different types of leaves of absence available, the maximum length and types of benefits available while on a leave of absence, employee contributions requirements, and the procedures for paying your share of premiums.

Note that Dependent Care FSA Participants are not eligible to participate in the Dependent Care FSA while on leave of absence.

Family and Medical Leave Act

In the event Santa Clara University employs 50 or more individuals within a 75-mile radius, Santa Clara University will be subject to the Family and Medical Leave Act of 1993 ("FMLA"). FMLA generally allows eligible employees to take a specific amount of job-protected, unpaid leave for certain family and medical reasons specified under the law and its regulations, as amended from time to time.

If you take FMLA leave, you may continue your group health care coverage under the Plan (e.g. medical, dental, vision, Health FSA) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave.

- If you are being paid directly by Santa Clara University and you substitute accrued paid leave for some of your unpaid FMLA leave days (e.g. both types of leaves run concurrently), your share of premiums will continue to be deducted from your pay (on a pre-tax basis, if applicable).
- If you take an unpaid leave of absence that qualifies under FMLA, you may continue to maintain your health care benefits on the same terms and conditions as though you were still an active employee by paying any normally required contributions for your health care benefits in accordance with Santa Clara University's FMLA policies and applicable law. If you do not make such payments, or do not make them in a timely manner, your health care coverage may cease. At least 15 days before cessation of your health care coverage, you will be provided with notice of the cancellation. Unless Santa Clara University has adopted a longer grace period, you will have 15 days from the date of the notice to make the required payment.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments attributable to the period prior to your return from leave, if applicable. If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections.

If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage. You also may be required to reimburse Santa Clara University for the cost of coverage provided to you while you were on unpaid FMLA leave (the cost equals the COBRA premium, without a 2% add-on), unless your failure to return to employment is due to a serious health condition, the need to care for a servicemember, or because of other circumstances beyond your control.

For additional information on FMLA leave, and for information on participant contributions to Plan coverage during FMLA leave, please contact the Plan Administrator.

Special FMLA Rules for Health FSAs. If you participated in the Health FSA prior to revoking or ceasing coverage during your leave of absence, you will have two coverage options upon return to active employment: 1) you may elect to reinstate a level of coverage that is prorated (reduced by the amount of contributions missed during leave); or, 2) You may elect to reinstate your original coverage level.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take a military leave under USERRA, whether for active duty or for training, you are entitled to extend your health care coverage (e.g. medical, dental, vision, Health FSA) for up to 24 months as long as you give Santa Clara University advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total leave, when added to any prior periods of military leave from Santa Clara University, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (and any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated (e.g. you do not elect the extended coverage), when you return to work with Santa Clara University you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health care coverage under the Plan.

If you do not return to work at the end of your military leave you may be entitled to continue coverage under COBRA continuation coverage for the remainder of the COBRA continuation period, if any. Any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible.

These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Applicable State or Municipal Law

Santa Clara University shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

Premium Contribution Benefits

The Premium Contribution Benefits available under the Plan allow you to pay for your share of eligible premium costs with pre-tax dollars through payroll deductions. The enrollment materials provided to you when you first became eligible and thereafter during the annual Open Enrollment period contain a list of available Premium Contribution Benefits, as well as your cost for coverage in each benefit plan. Appendix B provides a brief summary of the Premium Contribution Benefits available under the Plan and the contribution requirements for each benefit choice.

The terms and conditions of the underlying benefits, including eligibility for coverage, claims and appeals procedures, and details regarding the benefits provided are stated in the applicable Benefit Plan's Benefit Documents and are not governed by this Plan

Santa Clara University, at its discretion, requires employee contributions as a condition of participation in each Premium Contribution Benefit. Each year, Santa Clara University will evaluate all benefit costs and shall make adjustments for the following Plan Year. You will be notified of any changes in your enrollment materials prior to each Plan Year.

Health Savings Account

The Health Savings Account ("HSA") allows you to set aside pre-tax dollars that can be used to cover most unreimbursed health care expenses (including dental and vision care expenses) provided they qualify as tax deductible under Internal Revenue Service ("IRS") rules. Unlike the Health FSA, the funds remaining in your HSA account at the end of a Plan Year are not forfeited.

When you elect to make HSA contributions through payroll deductions, your pay is reduced each pay period by the amount you specify in your election and a corresponding amount is forwarded to your HSA account. HSA funds are deposited pre-tax and earn tax-free interest. When used to reimburse qualified health care expenses, HSA distributions are also non-taxable.

Your HSA is an individual bank account in your name. This account is not maintained, sponsored, or endorsed by Santa Clara University, nor is it subject to ERISA. You are solely responsible for managing your HSA to ensure that contributions qualify for favorable tax treatment and that funds are used only for qualified health care expenses.

Qualified HSA Health Care Expenses

Your HSA can be used to pay for qualified health care expenses that apply toward your HDHP deductible. Additionally, you can pay for qualified health care expenses that your HDHP doesn't cover. See Appendix C for a partial list of allowable expenses.

For more details, refer to IRS Publication 502. Please be advised that the IRS can amend the list of eligible expenses at any time, with or without prior notice.

A distribution of funds for reasons other than qualified health care expenses prior to age 65 is taxable and subject to a 20% additional penalty.

HSA Contribution Limits

Up to certain limits, contributions to an HSA are tax deductible. In general, you are permitted to contribute the sum of the monthly limitations for months during the taxable year that you are covered through an HDHP and therefore eligible to make an HSA contribution. The monthly limitation for any month is 1/12 of the applicable contribution limit described in Appendix B. You may choose to contribute up to the maximum contribution limitation for a taxable year as long as you are enrolled in an HDHP during the last month of the taxable year. If you contribute the maximum amount and do not remain covered by an HDHP for the 12-month period following the end of the tax year in which you first enrolled in the HDHP, you will be subject to income tax and a 10% penalty tax on amounts that you would not normally have been permitted to make on a pre-tax basis.

Changing Your HSA Election

You may increase, decrease, or revoke your HSA contribution election at any time during the Plan Year for any reason by following the procedures established by the Plan Administrator. Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change.

Cessation of HSA Eligibility

If you cease to be an HSA-Eligible Individual (e.g., because you become entitled to Medicare or enroll in impermissible non-HDHP coverage) you may still receive tax-free HSA distributions for Qualified Medical Expenses (or may withdraw funds on a taxable basis for nonmedical expenses), but the Plan will cease to make HSA contributions on your behalf on a tax-favored basis.

Health FSA Benefits

You can use a Health FSA for health care expenses that your medical, dental, and vision Benefit Plans do not cover. You also can use it to pay for your share of the cost of health care expenses, including copayments, coinsurance, and prescription drugs.

General Purpose vs. Limited Purpose Health FSAs

The Plan offers two types of Health FSAs: General-Purpose Health FSA and Limited-Purpose Health FSA.

- The General-Purpose Health FSA allows you to be reimbursed for eligible medical, prescription, dental, and vision care expenses incurred during the Plan Year.
- The Limited-Purpose Health FSA allows you only to be reimbursed for dental, vision care, and certain preventive care expenses incurred during the Plan Year.

The Limited-Purpose Health FSA allows HSA enrollees to elect both HSA and Health FSA benefits during a Plan Year. Participating in both benefits allows you to maximize your tax savings.

Eligible Health Care Expenses

Your Health FSA contributions can be used to pay for a wide variety of health care expenses defined as "deductible" by tax law. The expenses cannot be payable under any other health plan and must be incurred by either you or your dependents who meet the eligibility requirements.

See Appendix C for a partial list of allowable expenses. For the most up-to-date list of qualified health care expenses refer to IRS Publication 502. Please be advised that the IRS can amend this list at any time, with or without prior notice.

Maximum Contribution Amount

The IRS sets the maximum amount you can contribute to a Health FSA. See Appendix B for details.

The annual salary reduction amount you elect to contribute to your Health FSA (less any prior reimbursements) will be available in full at all times during the Plan Year.

Uniform Coverage Rule

The "Uniform Coverage Rule" requires that the maximum amount of reimbursement from a Health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage)."

Use or Lose Rule and Account Carryovers

If any balance remains in your Health FSA after the end of any Plan Year after all reimbursement requests have been processed, then such ending balance in excess of permissible carryover amount shall be forfeited. In such event, you will have no further claim to the forfeited funds for any reason and the Plan Administrator will use such funds as described in "Experience Gains" section.

The Plan Administrator will "carryover" any unused balance of up to permissible carryover amount remaining in your Health FSA at the end of a Plan Year and will apply it to your Health FSA balance for the subsequent Plan Year. The carried over funds do not affect your salary reduction election for the subsequent Plan Year and may be used to reimburse health care expenses.

Run-Out Period for Submitting Claims. In general, you will have 90 days from either the end of the Plan Year or your last day of Plan participation, whichever is earlier, to submit Health FSA claims for health care expenses incurred during the Plan Year. After that time, you will forfeit any funds remaining in your account. The rollover of the carryover funds will occur after the 90-day run-out period is complete.

Continuation of Coverage Rights

See the "Continuation of Coverage Rights" section of this SPD for additional details on a participant's rights to continue Health FSA coverage under the Plan for a limited period after experiencing a loss of coverage due to a qualifying event, such as voluntary or involuntary job loss, reduction in hours worked, death, divorce, or other life events.

Under most circumstances, COBRA continuation coverage is provided to qualified individuals on an after-tax

basis. Individuals whose COBRA continuation coverage may be provided on a pre-tax basis are limited to current employees (as permitted by the Plan Administrator on a uniform and consistent basis) whose COBRA continuation coverage arises either because of a reduction of hours or because the participant's dependent ceases to satisfy the underlying Benefit Plan's eligibility requirements even though the dependent's COBRA continuations coverage continues to qualify for exclusion from the participant's income.

Qualified Military Reservist Distribution

Notwithstanding other provisions of this Plan to the contrary, any employee/reservist who is called to Active Duty in the Armed Forces may elect to receive a distribution of unused Health FSA balances under the following circumstances:

- The period of active duty is for at least 180 days;
- The amount withdrawn is no greater than the actual cash contributions made to the Plan in that Plan Year up to the date of the withdrawal;
- The request for distribution is made and the distribution occurs no later than the last day of the Plan Year, or the end of the run-out period or the end of the period in which claims may be filed for that Plan Year, whichever is later, and,
- The amount received is treated by the employer as taxable income.

Dependent Care FSA Benefit

If you have young children or care for a disabled dependent, you can use the Dependent Care FSA to pay for qualifying, work-related dependent care expenses with pre-tax dollars. To be eligible for this benefit, you (and your spouse, if you are married and your spouse is not disabled or a full-time student) must be at work during the time your eligible dependent is receiving care.

Dependent Care FSA vs. Dependent Care Tax Credit

If you choose to pay some or all of your dependent care expenses through the Dependent Care FSA, you cannot take advantage of the Federal Dependent Care Tax Credit for the same expenses. For some people, the tax credit may result in greater savings than participation in the Dependent Care FSA, especially if household earnings are less than $25,000 per year. You should compare both options to determine which approach provides you with the greatest savings. If you have questions, refer to IRS Publication 503 or consult your tax advisor.

Maximum Contribution Amount

If you elect to participate in the Dependent Care FSA, you can contribute up to $5,000 ($2,500 if married filing separately) per Plan Year toward your dependent care expenses.

Any amounts contributed to your account in excess of the above limits during a Plan Year will be included in your taxable income and wages. Unlike the Health FSA, you can be reimbursed from your Dependent Care FSA only up to the amount that you have contributed to your Dependent Care FSA.

Contribution Limits for Highly Compensated Employees. The Code has certain nondiscrimination rules which may require the Plan Administrator to limit the contribution amounts elected by highly compensated employees during a Plan Year. You will be notified if this limitation applies to you.

Use or Lose Rule

If any balance remains in your Dependent Care FSA after the end of any Plan Yearafter all reimbursement requests have been processed, then such ending balance shall be forfeited. In such event, you will have no further claim to the forfeited funds for any reason and the Plan Administrator will use such funds as described in "Experience Gains" section.

Run-Out Period for Submitting Claims. You will have 90 days from the end of the Plan Year or your last day of Plan participation, whichever is earlier, to submit Dependent Care FSA claims for dependent care expenses incurred during the Plan Year. After that time, you will forfeit any funds remaining in your account.

Eligible Dependents

The definition of dependent under the Dependent Care FSA is an individual who is your qualifying child, qualifying spouse, or qualifying relative, as follows:

- 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 (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her 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 chld with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

Eligible Dependent Care Expenses

Eligible dependent care expenses that can be reimbursed from your Dependent Care FSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work. Eligible dependent care expenses include, but are not limited to, the following expenses if not otherwise excluded (review IRS Publication 503 for additional qualified dependent care expenses):

- Dependent care costs that you must pay to enable you to work. If you are married, your spouse also must be employed full-time, be a full-time student or incapable of self-care;
- Dependent care for a dependent who is under 13 years of age – the IRS requires the provider to be a qualified day care center or a person who is not your dependent. A relative age 19 or older can provide qualified dependent care assistance if you do not claim him or her as a dependent for income tax purposes;
- Non-nursing care for a dependent 13 years of age or older who is physically or mentally incapable of self-care;
- Nursery school, day care center that meets local regulations or babysitter fees only for purposes of maintaining gainful employment for you and your spouse or if you or your spouse is a full-time student or incapable of self-care;
- Certified "away from home" facilities (providing not more than 12 hours per day).

Examples of ineligible expenses include

- Food or clothing;
- Costs for a dependent's education (other than education a nursery school provides);
- Expenses for transportation of a dependent to and from the provider of dependent care services except where transportation is required to maintain gainful employment (such as a school bus to and from the dependent care provider);
- Fees to a day care center that do not comply with all laws applying to child care centers;
- Dependent care costs that are covered by the federal tax credit for dependent care on your federal tax returns;
- Costs for a nursery school, day care center or babysitter outside of scheduled working hours.

Ineligible Expenses While on Leave

If a Participant in the Dependent Care FSA takes a paid or unpaid leave of absence lasting longer than 14 consecutive calendar days, Dependent Care Expenses shall not include expenses incurred after the fourteenth day of the leave and through the end of the leave.

REIMBURSEMENT AND CLAIMS PROCEDURES

The Plan Administrator will act as, or will designate, a claims administrator to decide your claim ("Claimant") in accordance with its reasonable claims procedures, as required by applicable law. If the claims administrator 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 for a review of the denied claim. The claims administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by applicable law.

Premium Contribution Benefits

A Plan participant is neither required nor permitted to file Claims for Premium Contribution Benefits. If you have questions about this Benefit, please contact Santa Clara University's Director of Employee Development and Wellness at 408-554-4932. To file a claim or appeal for medical, dental, or vision benefits, a Claimant must follow the procedures set forth in the Benefit Document for the applicable Component Plan.

HSA Benefits

Your HSA is an individual account. The procedure for filing for reimbursements under the HSA shall be determined by the HSA trustee/custodian and not by this Plan. This means that you do not have to request approval from the Plan to receive a distribution. You are responsible for determining whether expenses reimbursed by your HSA are qualified HSA expenses, and for any adverse tax consequences from a non-qualified withdrawal.

Health FSA Reimbursements

Reimbursements under the Health FSA must be submitted pursuant to procedures established by the claims administrator.

Debit Card Payments. Payments from your Health FSA for qualified health care expenses will occur automatically if you pay your health care provider using a debit card provided by the claims administrator. You must comply with the card substantiation procedures by providing any requested documentation that supports your reimbursement.

Manual Submissions. In general, a Health FSA participant may apply for reimbursement by submitting a request to the claims administrator in such form as the claims administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the health care expense was incurred (or 90 days after the date eligibility ceases). At minimum, the request for reimbursement must include:

- The name of the person or persons who incurred the health care expenses;
- 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 Claimant will not seek reimbursement through any other source; and,
- Other such details about the expenses that may be requested by the claims 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 Claimant).

The reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party showing that the health care expenses have been incurred and the amounts of such expenses, along with any additional documentation that the claims administrator may request.

Requests for reimbursement should be sent to:

WEX Health
PO Box 2926
Fargo, ND 58108-2926
866-451-3399
www.wexinc.com

Claims for Health FSA Benefits

Within 30 days after receipt by the claims administrator of a reimbursement request from Claimant, the claims administrator will reimburse the Claimant for the health care expenses (if the claims administrator approves the claim), or the claims administrator will notify the Claimant 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 claims administrator, including in cases where a reimbursement claim is

incomplete. The claims administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Claimant 45 days in which to complete the previously incomplete reimbursement claim.

If the claims administrator does not fully agree with the claim, the Claimant shall receive an adverse benefit determination ("Adverse Determination"). The Notice of Adverse Determination must be written in a manner calculated to be understood by the Claimant and shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the applicable time limits;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- If applicable, specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. Such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) after an appeal.

Health FSA Claims Appeal Procedures

First Appeal. If the Claimant disagrees with an Adverse Determination, the Claimant or the Claimant's appointed representative may formally request an appeal by following the claims administrator's appeal procedures. The Claimant may appeal any Adverse Determination within 180 days of receipt of such a denial by submitting a written request for review to the Administrator. If the Claimant does not appeal in a timely manner, the Claimant will lose the right to later object to the adverse determination on review ("Appeal Decision").

If the claim on appeal is wholly or partially denied, the claims administrator will provide the Claimant with a written notification of the Plan's Appeal Decision, within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan. Any determination by the claims administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the claims administrator or delegate acted arbitrarily and capriciously. The notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Plan provisions on which the Appeal Decision is based;
- A statement regarding the Claimant's right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about such procedures;
- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a).

Second Appeal. If specified in the Benefit Documents for the Health FSA or in documentation given to you by the Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The Appeal Decision with respect to any second appeal will be made within a reasonable period of time, but not later than 30 days after receipt of the second appeal by the Plan.

Dependent Care FSA Reimbursements

Reimbursements under the Dependent Care FSA must be submitted pursuant to procedures established by the claims administrator.

Debit Card Payments. Payments from your Dependent Care FSA for qualified dependent care expenses will occur automatically if you pay your dependent care provider using a debit card provided by the claims

administrator. You must comply with the card substantiation procedures by providing any requested documentation that supports your reimbursement.

Manual Submissions. In general, a Dependent Care FSA participant may apply for reimbursement by submitting a request to the claims administrator in such form as the claims administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Dependent Care Expense was incurred (or 90 days after the date eligibility ceases). At minimum, the request for reimbursement must include:

- The name of the person or persons on whose behalf the 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 Claimant 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 9.3; and,
- Other such details about the expenses that may be requested by the claims administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the participant).

The reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party showing that the dependent care expenses have been incurred and the amounts of such expenses, along with any additional documentation that the claims administrator may request.

Requests for reimbursement should be sent to:

WEX Health
PO Box 2926
Fargo, ND 58108-2926
866-451-3399
www.wexinc.com

Dependent Care FSA Claims Procedures

Within 90 days after receipt by the claims administrator of a reimbursement request from a Claimant, the claims administrator will reimburse the Claimant for the dependent care expenses (if the claims administrator approves the claim), or the claims administrator will notify the Claimant that his or her claim has been denied.

If the claims administrator does not fully agree with the claim, the Claimant shall receive an adverse benefit determination ("Adverse Determination"). The Notice of Adverse Determination must be written in a manner calculated to be understood by the Claimant and shall include the following information:

- References to the specific Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed; and,
- An explanation of the Plan's claims procedures.

Claims Appeal Procedures

If the Claimant disagrees with an Adverse Determination, the Claimant or the Claimant's appointed representative may formally request an appeal by following the claims administrator's appeal procedures. The Claimant may appeal any Adverse Determination within 60 days of receipt of such a denial by submitting a written request for review to the Administrator. If the Claimant does not appeal in a timely manner, the Claimant will lose the right to later object to the adverse determination on review ("Appeal Decision").

If the claim on appeal is wholly or partially denied, the claims administrator will provide the Claimant with a written notification of the Plan's Appeal Decision, within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan. Any determination by the claims administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the claims administrator or delegate acted arbitrarily and capriciously. The notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision; and,
- References to the specific Plan provisions on which the Appeal Decision is based.

CONTINUATION OF COVERAGE RIGHTS

This Section applies only to the Health FSA provisions of this Plan. If you have opted to contribute to a Health FSA under this Plan, then read this entire notice carefully.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Health FSA coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Health FSA when they would otherwise lose that coverage. For additional information about your rights and obligations under the Health FSA and under federal law, you should review this SPD or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health FSA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Health FSA is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your Health FSA coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your Health FSA coverage 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 his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose Health FSA coverage because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

President & Board of Trustees of Santa Clara College
dba Santa Clara University
Attn: Director of Employee Development and Wellness
500 El Camino Real
Santa Clara, CA 95053
408-554-4932

Note that you may lose your right to elect COBRA Coverage if proper procedures are not followed.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each qualified beneficiary will receive an Election Notice, which must be completed and returned within 60 days.

Special COBRA Rule for Health FSAs

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by 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 will only last until the end of the Plan Year during which the qualifying event occurred. **The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount) will be forfeited at the end of the Plan Year and the Health FSA COBRA coverage will be terminated**.

Any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse qualified health care expenses until the end of the qualified beneficiary's COBRA coverage period.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Santa Clara University Section 125 Cafeteria Plan
President & Board of Trustees of Santa Clara College
dba Santa Clara University
500 El Camino Real
Santa Clara, CA 95053
408-554-4932

STATEMENT OF ERISA RIGHTS

This Statement of ERISA Rights applies to the Health FSA benefit under this Plan. If you are enrolled in the Health FSA benefit, you are entitled to certain rights under the Employment Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants in the Health FSA Benefit are entitled to the following.

Receive Information about Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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 your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting

group health plans, or if you need assistance in obtaining documents from the Plan Administrator, 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). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

Plan Administration

Santa Clara University is the Plan Administrator of the Plan and a Named Fiduciary within the meaning of such terms under applicable law. Santa Clara University is the Plan's agent for service of legal process.

Santa Clara University has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of Santa Clara University, furnish to Santa Clara University such data and information as Santa Clara University shall require in the performance of its duties under the Plan.

Santa Clara University may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

Santa Clara University may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and applicable law.

Santa Clara University will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Amendment and Termination

President & Board of Trustees of Santa Clara College dba Santa Clara University intends to maintain the Plan indefinitely but is under no obligation to continue the Plan and can terminate the Plan without liability by providing written notice to all then current Plan participants. In amending or terminating the Plan, Santa Clara University cannot retroactively reduce the benefits to which you are entitled prior to the termination or amendment.

President & Board of Trustees of Santa Clara College dba Santa Clara University intends to maintain the Plan as a tax-qualified plan under the Internal Revenue Code. In order to obtain and/or maintain such status, Santa Clara University may be required to make subsequent amendments to the Plan. Some amendments might be made on a retroactive basis.

Experience Gains

If the Health FSA has an experience gain with respect to a Plan Year, such experience gain may be used to pay expenses of the Health FSA, or for such other uses that are determined by the Plan Administrator to be consistent with applicable laws and regulations. If the Dependent Care FSA has an experience gain with respect to a Plan Year, such experience gain may be used to pay expenses of the Dependent Care FSA, or for such other uses that are determined by the Plan Administrator to be consistent with applicable laws and regulations.

In no event shall experience gains be allocated among Participants based, directly or indirectly, on the level of their Health FSA or Dependent Care FSA reimbursement amounts.

Change in Benefit Cost

If a Benefit Plan expense under this Plan increases or decreases during a Plan Year, then the Plan may automatically increase or decrease, as the case may be, the required periodic contribution of all affected Participants for such benefits.

Privacy and Security of Information

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

Legal Actions

Any legal action relating to, arising out of, or involving, the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of California.

The time limit for bringing any lawsuit that arises under or relates to the Health FSA (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under the Plan, a Claimant must complete the applicable claims procedure set out in the Plan or Benefit Documents (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the Claimant's right to file a lawsuit with respect to the claim.
- Any lawsuit seeking benefits related to the Health FSA must be brought within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable for you or your dependents under the Plan may not be assigned to anyone. Additionally, to the extent any assignment of benefits is permitted under any Elective Benefit, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. As such, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this SPD is a general discussion of the relevant provisions of the Plan found in the official Plan and Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

SANTA CLARA UNIVERSITY SECTION 125 CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

Participation and Eligibility Requirements

Employee Eligibility

An Employee who is determined to be benefit-eligible as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified below.

Employee Class	Benefit Option	Effective Date of Eligibility	Working Hours Requirement
Full-Time Employees	Premium Contribution Benefits, General-Purpose Health FSA, Dependent Care FSA	First day of the month coinciding with or following date of hire	20 hours per week
HSA-Eligible Full-Time Employees enrolled in the HDHP medical plan	HSA, Limited-Purpose Health FSA	First day of the month coinciding with or following date of hire	20 hours per week

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACA-FT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event Santa Clara University adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

HSA-Eligible Individuals

You may be eligible to enroll in and contribute to the HSA if:

- You are currently enrolled in Santa Clara University's qualifying high-deductible health plan ("HDHP");
- You are *not* enrolled in any other disqualifying non-HDHP health plan (including a General-Purpose Health FSA), Medicare, Medicaid, or TRICARE); and,
- You *cannot* be claimed as a dependent on another individual's tax return (most commonly as the taxpayer's dependent child or as a household member for whom the taxpayer provides over half of your support and your gross income does not exceed the personal exemption amount).

An individual's status as an HSA-Eligible Individual is determined monthly as of the first day of the month. The HSA contribution limit is calculated each month, and a contribution can be made for months in which the individual actually meets or is treated as meeting all the requirements for HSA eligibility.

Rehire Rule

Unless otherwise specified to the contrary in the Benefit Documents for a Component Plan, an employee who is rehired prior to the end of a 13-consecutive week period of time after date of termination will be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

APPENDIX B

SANTA CLARA UNIVERSITY SECTION 125 CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

Summary of Benefits and Contribution Requirements

Effective as of January 1, 2024 benefits and Employee contribution requirements of the Santa Clara University Section 125 Cafeteria Plan are as follows:

Elective Benefits

The following Elective Benefits are available under the Plan:

- Premium Contribution Benefits:
  - Group Medical
  - Group Dental
  - Group Vision
- General-Purpose Health FSA
- Limited-Purpose Health FSA
- Dependent Care FSA
- HSA

The above Elective Benefits are described in the applicable Benefits Documents provided by each carrier, contract administrator, and HSA administrator, which are incorporated herein by reference.

Premium Contribution Requirements

Prior to the beginning of a Plan Year, Santa Clara University, at its discretion, may make changes to the benefits and contribution requirements. The cost sharing requirements for Premium Contribution Benefits are detailed in the Annual Open Enrollment materials provided to eligible Employees, which are incorporated herein by reference. **Copies of enrollment materials are available upon request by contacting:**

President & Board of Trustees of Santa Clara College dba Santa Clara University
Attn: Director of Employee Development and Wellness
500 El Camino Real
Santa Clara, CA 95053
408-554-4932

Health FSA, Dependent Care FSA, and HSA Limits and Deadlines

Participants may make contributions to these accounts, subject to the account maximums specified below, in the manner determined by the Plan Administrator and may not exceed the full amount elected in any one Plan Year.

Health FSA	Account Details
Maximum Contribution Amount per Plan Year:	Up to the statutory maximum limit per Plan Year in accordance with Code Section 125(i)(2) (cost of living adjustment). For example, for the 2024 Plan Year, the maximum limit is $3,200.
Minimum Contribution Amount per Plan Year:	$300

Health FSA	Account Details
Health FSA Carryover Maximum:	If funds remain in your Health FSA at the end of the Plan Year, up to 20% of the current Plan Year's Maximum Contribution Amount will be carried over for your use in the subsequent Plan Year. For example, up to $640 of unused funds may rollover to your 2025 account.
Run-Out Period for sending in Reimbursement Requests:	90 days after the end of the Plan Year in which the expense was incurred (March 31 of the following Plan Year).
Dependent Care FSA	**Account Details**
Maximum Contribution Amount per Plan Year:	
▪ Single or married filing jointly	Up to $5,000 per plan year
▪ Married filing jointly and spouse's earned income is less than $5,000 per year	Up to spouse's earned income per plan year
▪ Married filing separately	Up to $2,500 per plan year (spouse may also contribution $2,500 to a separate Dependent Care Assistance Program
Minimum Contribution Amount per Plan Year:	$600
Run-Out Period for sending in Reimbursement Requests:	90 days after the end of the Plan Year in which the expense was incurred (March 31 of the following Plan Year).
HSA	**Account Details**
Maximum HSA Contributions per Calendar Year:	Depending on your election and age, you may contribute up to the IRS's statutory maximum limit for individual or family coverage per Plan Year in accordance with Code Sections 223(b)(2)(A), 223(b)(2)(B), and 223(b)(3).
▪ 2024 Calendar Year – HDHP Individual Coverage:	$4,150 ($5,150 if Participant is age 55 or older).
▪ 2024 Calendar Year – HDHP Family Coverage	$8,300 ($9,300 if Participant is age 55 or older).

APPENDIX C

SANTA CLARA UNIVERSITY SECTION 125 CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

Partial List of Qualified Health Care Expenses

IRS regulations require that you keep all receipts and any documentation for eligible health care expenses with your personal tax records. Generally, eligible expenses are those not covered by your medical, dental, or vision plans. They must be meant to diagnose, cure, mitigate, treat, or prevent illness or disease. For more details, refer to IRS Publication 502. Please be advised that the IRS can amend the list of eligible expenses at any time, with or without prior notice.

The following is a partial list of qualified health care expenses for HSAs and General-Purpose Health FSAs:

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limbs
- Artificial teeth
- Birth control pills
- Birth prevention surgery
- Braces
- Braille reading material
- Care for mentally handicapped
- Chiropractors
- Christian Science Practitioners
- Co-Insurance payments
- Contact lenses
- COVID-19 Home Testing Kits
- COVID-19 PPE
- Crutches
- Deductibles
- Dental fees
- Dentures
- Diagnostic fees
- Eyeglasses
- Eye examination
- Fee for practical nurse
- Fees for healing services
- Fees for licensed osteopaths
- Handicapped persons' schools (medical expenses)
- Hair transplants
- Hearing devices and batteries
- Home improvements motivated by medical considerations
- Hospital bills
- Hospitalization insurance
- Insulin
- Laboratory fees
- Laetrile by prescription
- Lead-based paint removal
- Life fee to retirement home for medical care
- Medical information plan
- Membership fees in association furnishing medical services, hospitalization, and clinical care
- Nurses' fees (including nurses' board and Social Security tax when paid by taxpayer)
- Obstetrical expenses
- Operations
- Orthodontia
- Orthopedic shoes
- Over-the-Counter Medicines and Drugs
- Over-the-Counter menstrual care products
- Oxygen
- Physicians' fees
- Physician-recommended swimming pool or spa expenses
- Prescribed medicine and drugs
- Psychiatric care
- Psychologist fees
- Mentally-disabled persons' cost for special home
- Routine physical and other non-diagnostic services or treatments
- "Seeing-eye" dog, and its upkeep
- Special communication equipment for the deaf
- Special education for the blind
- Special plumbing for the handicapped
- Sterilization fees
- Surgical fees
- Therapeutic care for drug and alcohol addiction
- Therapy treatment
- Transportation for medical services
- Tuition at special schools for the handicapped
- Wheelchair
- Wigs
- X-rays

Orthodontic Expenses. Because orthodontic treatment often requires that you pay some or all of the full cost upfront, these expenses are treated differently than other health care expenses. You may pay a lump sum up front or make payments on a monthly basis provided that you submit proof of payment along with treatment start date and anticipated end date.

Limited Purposes Health FSA Limitations. If you participate in the Limited-Purpose Health FSA due to your enrollment in an HSA, you are limited to reimbursements for the following types of qualified health care expenses:

- 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 Section 223©(2)©. This may include prescribed drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

Examples of Ineligible Expenses:

- Insurance premiums
- Personal use items (e.g. toothpaste, cosmetics)
- Family or marriage counseling