THE UNIVERSITY OF CHICAGO
CAFETERIA PLAN

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ARTICLE I
INTRODUCTION

The University of Chicago has established The University of Chicago Cafeteria Plan (the "Plan"), formerly The University of Chicago Flexible Spending Plan, amended and restated effective December 1, 2020, to allow Eligible Employees to pay their University welfare benefit plan premiums on a pre-tax basis, to contribute to a health flexible spending account on a pre-tax basis, to contribute to a dependent care flexible spending account on a pre-tax basis, and/or for such other benefits as the Plan may provide hereunder.

The University intends that the Plan qualify as a "cafeteria plan" within the meaning of Code Section 125, and further intends that the Benefits an Eligible Employee elects to receive under the Plan be excludable from the Employee's income under Code Section 125(a) and other applicable sections of the Code. The Health Care Flexible Spending Account is intended to qualify as a Code Section 105 medical expense reimbursement plan. The Dependent Care Flexible Savings Plan is intended to qualify as a Code Section 129 dependent care assistance plan. The Health Savings Account is intended to qualify as a Code Section 223 health savings account. Although printed within this document, the Health Care FSA and Dependent Care FSA are each a separate written plan for purposes of administration and nondiscrimination requirements imposed by Code Sections 105 and 129 and all applicable provisions of ERISA.

This document is subject to the Appendices attached hereto and their provisions shall be incorporated in the Plan by this reference. This document, together with its Appendices, shall comprise the written plan document for the Plan.

ARTICLE II
DEFINITIONS

The capitalized words and phrases in the Plan shall have the meanings set forth below:

1.1 Administrator means the University, unless another person or entity has been designated by the University pursuant to Section 11.1.

1.2 Affiliated Employer means any entity that is considered, together with the University, to be a single employer in accordance with Code Section 414(b), (c), (m), or (o).

1.3 Benefit means those benefits or coverages available for election by a Participant under Section 3.1.

1.4 Benefit Document means any insurance contracts, benefits booklets, and plan documents governing a Benefit.

1.5 Board of Trustees means the Board of Trustees of the University, or a duly appointed committee thereof, as each may from time to time be constituted.

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

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

1.8 Compensation means cash wages or salary paid to an Employee by the University.

1.9 Dependent means an individual who qualifies as a dependent of a Participant under Code Section 152 (as modified by Code Section 105(b)). For purposes of the Premium Payment Benefit and Health Care FSA, "Dependent" does not include any individual who is not a dependent under the Health Care Plan.

For purposes of the Premium Payment Benefit for the payment of Premiums for group health coverage under the Health Care Plan and the Health Care Flexible Spending Account, "Dependent" includes a Participant's natural child, stepchild, foster child, adopted child, and a child placed with the Participant for adoption who is age 26 or younger.

Any child of a Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Section 609 will be considered a Dependent under this Plan, as applicable.

The criteria for determining a Dependent need not be identical among the Benefits or the same as under the Health Care Plan.

1.10 Dependent Care Expenses means the expenses described in Section 8.5.

1.11 Dependent Care Flexible Spending Account or Dependent Care FSA means the dependent care assistance plan account described in Article VII.

1.12 Election Period means a period of time immediately preceding the beginning of each Plan Year, as determined by the Administrator, during which an Eligible Employee can make certain elections as provided under the Plan. Such period will be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period will be determined pursuant to Section 5.1.

1.13 Eligible Employee means an Employee who is regularly scheduled to work at least 20 hours per week and who is classified as an Eligible Employee as determined from the payroll and personnel records maintained by the University. An Employee's work schedule shall be determined by the Administrator based on the payroll or personnel records maintained by the University at the time the services are performed and shall be binding and conclusive for purposes of the Plan. Notwithstanding the foregoing:

(a) leased employees shall not be eligible to participate in the Plan.

(b) the following Employees are Eligible Employees as follows:

(i) for purposes of the Premium Payment Benefit, an Employee who is required to pay Premiums under the Health Care Plan; and

(ii) for purposes of the Health Savings Account, an Employee who participates in qualifying high-deductible health coverage offered by the Employer and does not participate in any disqualifying non-high deductible health coverage.

(c) if a Participant or his or her Spouse has elected to participate in a general-purpose health flexible spending account (under this Plan or otherwise) or a health reimbursement account (HRA), the Participant is not eligible to participate in the HSA during the health FSA's or HRA's plan year, and vice versa.

Eligibility is subject to additional requirements specified in the Benefit Documents and/or Health Care Plan.

1.14 Employee means any common law employee of the University as determined by the payroll or personnel records maintained by the University at the time the services are performed. The term Employee includes leased employees within the meaning of Code Section 414(n)(2).

If any individual is classified by the Employer as an individual not eligible to participate in the Plan, and the Employer subsequently is required by any government agency, court, or other tribunal to reclassify any such individual as an Employee who would be eligible to participate in the Plan, such individual will not be eligible to participate in the Plan unless and until he or she is

specifically designated by the Employer as eligible. Such designation will provide for eligibility only prospectively from the time the designation is made.

1.15 Employer means The University of Chicago and any successor that will maintain this Plan.

1.16 Enrollment Date means the effective date of enrollment of a Participant, as follows or as specified by the Administrator in the Plan's enrollment materials or summary of benefits:

(a) New Hires. The Enrollment Date shall be the first day of the month following the date the Administrator processes the Eligible Employee's election to participate under Section 5.1, provided the enrollment election is properly completed within thirty-one (31) following the Eligible Employee's date of hire;

(b) Newly Eligible Employees. The Enrollment Date shall be the first day of the month following the date the Administrator processes the Eligible Employee's election to participate under Section 5.1, provided the enrollment election is properly completed within thirty-one (31) days following the date the Employee becomes an Eligible Employee.

(c) Ongoing Eligible Employees. The Enrollment Date shall be the January 1 following the Election Period during which the Eligible Employee submits a properly completed election to participate in the Plan.

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

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

1.19 Health Care Flexible Spending Account or Health Care FSA means the health care flexible spending account arrangement described in Article VI.

1.20 Health Care Plan means The University of Chicago Health Care Plans and such other welfare benefit plans maintained by the University for its employees.

1.21 Health Savings Account or HSA means the health savings account described in Article VIII.

1.22 Highly Compensated Employee means a highly compensated participant as defined in Code Section 125(e), a highly compensated employee as defined in Code Section 129(d)(2), or a highly compensated individual as defined in Code Section 105(h)(5).

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

1.24 Key Employee means an individual who is a "key employee" as defined in Code Section 125(b)(2).

1.25 Medical Expenses means the expenses described in Section 7.5.

1.26 Participant means any Eligible Employee who participates in the Plan pursuant to Article III and has not for any reason become ineligible to participate in the Plan.

1.27 Plan means The University of Chicago Cafeteria Plan, as set forth in this document, and all amendments thereto.

1.28 Plan Year means the 12-month period beginning each January 1 and ending on the following December 31.

1.29 Premiums mean the Participant's required contribution for coverage under the Health Care Plan.

1.30 Premium Payment Benefit means the Benefit described in Article VI.

1.31 Spouse means an individual who is legally married to an Employee (and who is treated as a spouse under the Code).

ARTICLE III
BENEFITS

3.1 Benefits. An Eligible Employee may elect to participate in any one or more of the following Benefits:

(a) Premium Payment Benefit (see Article VI).

(b) Health Care Flexible Spending Account (see Article VII).

(c) Dependent Care Flexible Spending Account (see Article VIII).

(d) Health Savings Account (see Article IX)

Health Care Plan benefits and coverage will be provided by the Health Care Plan, not this Plan. The types and amounts of benefits, the requirements for participating in the Health Care Plan, and the other terms and conditions of coverage and benefits of the Health Care Plan are set forth in the Health Care Plan. All claims to receive benefits under the Health Care Plan will be subject to and governed by the terms and conditions of the Health Care Plan, and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

3.2 Contributions. Each Participant may elect to reduce his or her Compensation, on a pre-tax basis, and receive in lieu of such Compensation certain optional Benefits as described in this Article III. Each Participant may designate a portion of Compensation for each Plan Year to be applied as Plan contributions toward any of the Benefits described in Section 3.1. Except as otherwise provided by the Administrator, Plan contributions will reduce the Participant's Compensation ratably on each payday beginning on or after the first day of the Participant's participation and will continue in effect for the Plan Year unless and until changed in accordance with Article V.

ARTICLE IV
PLAN PARTICIPATION

4.1 Participation. An Eligible Employee shall become a Participant in the Plan on the Enrollment Date following the Eligible Employee's election to participate under Article V.

4.2 Termination of Participation. A Participant will no longer participate in this Plan upon the occurrence of any of the following events:

(a) *Termination of employment*. The Participant's termination of employment, subject to the provisions of Section 4.3;

(b) *Death.* The Participant's death, subject to the provisions of Section 4.5;

(c) *Termination of eligibility.* The Participant's termination of eligibility, subject to the provisions of Section 4.6; or

(d) *Termination of the Plan.* The termination of this Plan, subject to the provisions of Section 12.2.

4.3 Termination of Employment. If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Plan will be governed in accordance with the following:

(a) *Health Care FSA.* The Participant's participation in the Plan will cease and no further Health Care FSA contributions will be made after the payroll date immediately following the date of termination. The Participant may submit claims for expenses that were incurred during the Plan Year up to the date of termination. To be eligible for payment, all such claims must be submitted no later than June 30 of the following the end of the Plan Year in which employment ended. Notwithstanding the foregoing, the Health Care Flexible Spending Account will be administered consistent with such further rights a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B (COBRA).

(a) *Dependent Care FSA Account***.** The Participant's participation in the Plan will cease and no further Dependent Care FSA contributions will be made after the payroll date immediately following the date of termination. However, such Participant may submit claims for Dependent Care Expenses incurred during the Plan Year up to the date of termination, and may receive reimbursement up to the amount in the Participant's Dependent Care FSA as of the date of termination. To be eligible for payment, all such claims must be submitted no later than June 30 of the following the end of the Plan Year in which employment ended.

(c) *Health Savings Account.* The Participant's participation in the HSA will cease and no further Plan contributions will be made under the Plan after the payroll date

immediately following the date of termination. The Participant's participation in the Health Savings Account will be governed by the terms of the applicable Benefit Documents.

(d) *Other Benefits.* The Participant's participation in the Premium Payment Benefit will cease and no further Plan contributions will be made after the date of termination, but coverage may continue for the remainder of the period of coverage with respect to which the required Premium has been paid, subject to the terms of the applicable Benefit Documents. With respect to any other Benefits not described in this Section 4.3, the Participant's participation in such Benefits will be governed by the terms of the applicable Benefit Documents.

4.4 Reemployment.

(a) *Eligible Employees.* The Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by the University within 30 days following termination of employment. If an Employee has a termination of employment and is subsequently reemployed by the University as an Eligible Employee more than 30 days following the date of termination, the Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of termination or to make a new election under the Plan.

(b) *Ineligible Employees.* An Employee who terminates employment with the University and who is subsequently reemployed by the University but is not an Eligible Employee may elect to participate in the Plan in accordance with Article V at the time the individual becomes an Eligible Employee.

4.5 Death. If a Participant dies, his or her participation in the Plan will cease. However, such Participant's personal representative may submit claims for expenses or benefits incurred prior to the date of death until the March 31 following the end of the Plan Year (or such other date as may be determined by the Administrator and communicated to Participants), with such reimbursements payable to the Participant's surviving Spouse or, if there is no Spouse, to the Participant's estate. The provisions of Code Section 4980B (COBRA) and related regulations will apply for purposes of the Health Care Flexible Spending Account.

4.6 Termination of Eligibility. If a Participant ceases to be an Eligible Employee, but remains as an Employee, his or her participation in the Plan will cease on the day in which the individual ceased being an Eligible Employee. The Participant may submit claims for expenses that were incurred during the Plan Year and prior to the day in which the individual ceased being an Eligible Employee. To be eligible for payment, all such claims must be submitted by the March 31 following the end of the Plan Year in which eligibility ceased. Notwithstanding the foregoing, the Health Care Flexible Spending Account will be administered consistent with such further rights a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B (COBRA).

4.7 Qualifying Leave under FMLA. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA, then, to the extent required by FMLA, the Participant will be entitled to continue the Participant's Benefits that provide group health coverage (including Health Care FSA benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment options provided by the Employer will be administered in accordance with the regulations issued under Code Section 125 and in accordance with FMLA.

4.8 Other Leave of Absence. If a Participant goes on a non–FMLA leave of absence, his or her participation in the Plan will be subject to the University's leave of absence polices (as revised from time to time), which are incorporated herein by reference. In general, and except as provided in such policies, if the leave of absence does not affect eligibility for Benefits under this Plan or for the Health Care Plan coverage chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid on a uniform and consistent basis in accordance with the University's internal policy and procedure. If a Participant goes on a leave that affects eligibility under this Plan or for the Health Care Plan coverage chosen by the Participant, the election change rules in Section 5.3 will apply. If the University's policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 Initial Elections. An Eligible Employee may elect to participate in this Plan within 31 days of his or her date of hire, in accordance with the terms prescribed by the Administrator, or within 31 days of the date he or she becomes an Eligible Employee, in accordance with Section 5.3. A newly Eligible Employee who does not elect to participate in the Plan at the time of his or her initial eligibility will not be eligible to enroll in the Plan until the next Election Period, except as provided for in Section 5.3.

Notwithstanding the foregoing or any Plan provision to the contrary, an Eligible Employee will automatically be enrolled in the Premium Payment Benefit as a Participant who has elected to make a contribution to the Plan equal to his or her Premiums under the Health Care Plan.

5.2 Annual Elections. During the Election Period immediately preceding each Plan Year, each Eligible Employee will be given the opportunity to elect whether to participate in the available Benefit under the Plan. Any such election will be effective for the Plan Year that immediately follows the end of the Election Period. A Participant may make his or her elections under the Plan by notifying the Administrator in writing of such elections in accordance with the Administrator's procedures.

(a) A Participant or Eligible Employee who did not previously elect to participate in the Plan or any Benefit may elect new Benefits under the Plan during the Election Period.

(b) A Participant who did previously elect to participate in the Plan or any Benefit may elect different or new Benefits under the Plan during the Election Period. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.3.

(c) A Participant who does not make a new election during the Election Period will be deemed to have elected to continue the same option with respect to the Premium Payment Benefit only and will not be considered a Participant for any other Benefits under the Plan.

5.3 Mid-Year Election Changes. A Participant may change a Benefit election or Plan contribution election after the Plan Year has commenced, in accordance with this Section 5.3.

(a) An Eligible Employee may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year (except as otherwise provided in Code Section 9801(f)) if, in the Administrator's determination and under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. No Participant

shall be allowed to reduce an election for the Health Flexible Spending Account or Dependent Care Flexible Spending Account to a point where the annualized contribution for such benefit is less than the amount already reimbursed. Notwithstanding anything herein to the contrary, if the rules and regulations adopted by the Department of Treasury conflict with the Plan, then such rules and regulations shall control.

Any new election must be submitted to the Administrator within 31 days following the change in status event, unless a longer period of time is noted below. Any new election shall be effective at such time as the Administrator shall prescribe. For purposes of this subsection, a change in status shall only include the following events and such other events permitted by Treasury regulations:

(i) *Legal Marital Status*. The Employee's marriage, divorce, legal separation, or annulment, or the death of a Spouse.

(ii) *Number of Dependents.* The birth, adoption, placement for adoption, or death of a Dependent; registration or termination of a civil union or domestic partnership, provided the domestic partner or civil union partner is a dependent under Code Section 152.

(iii) *Employment Status*. Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.

(iv) *Dependent satisfies or ceases to satisfy the eligibility requirements.* If a Participant's Dependent satisfies or ceases to satisfy the eligibility requirements for coverage due to the attainment of age limits or other similar circumstance. A Dependent becoming or ceasing to be a "Qualifying Individual" as defined under Code Section 21(b) will also qualify as a change in status for purposes of the Dependent Care FSA. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

(v) *Residency*. A change in the country of residence of the Employee, Spouse or Dependent that would lead to a change in coverage. In the event of a change in residence of the Participant and/or a change in state of residence of the Spouse or Dependent that results in a change in coverage, the Participant may only change his or her Premium Payment Benefit election with respect to medical and dental coverage under the Health Care Plan as determined by the Administrator.

(vi) *Special enrollment rights.* A Participant may change an election during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f)(3) (*i.e.,* under the Children's Health Insurance Program Reauthorization Act of 2009 or Title XIX of the Social Security Act (Medicaid)); provided that such Participant meets the

sixty (60) day notice requirement imposed by Code Section 9801(f). Such change will take place on a prospective basis. This subsection (vi) does not apply to Health Care FSAs.

(vii) *Qualified Medical Support Order*. In the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant will be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child under that Spouse's plan and such coverage is actually provided.

(viii) *Change in Dependent Care Coverage.* An Eligible Employee may change his or her Dependent Care FSA election if there is a change in dependent care coverage or a loss of dependent care coverage that is consistent with Section 1.125-4(f) of the Treasury Regulations.

(ix) *Change in Health Care Plan Coverage.* An Eligible Employee may change his or her Premium Payment Benefit election consistent with a midyear enrollment change under the Health Care Plan, to the extent such change is permitted under guidance or regulations issued by the Internal Revenue Service or Department of Treasury, and to the extent the change is permitted by the Administrator (on a uniform and non-discriminatory basis).

(b) *Health Savings Account*. An Eligible Employee may enroll in the HSA at any time during the Plan Year, subject to the requirements in Section 1.13(c), and may prospectively increase, decrease, or revoke his or her contributions to the HSA at any time during the Plan Year.

5.4 Limitations on Contributions and Benefits. The Administrator will determine, before or during any Plan Year, whether the Plan fails to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Employees who are considered Highly Compensated Employees, Key Employees and/or 5% owners under applicable Code provisions. The Administrator will take action that it deems appropriate, under rules uniformly applied to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, Key Employees and/or 5% owners, with or without the consent of such Employees.

ARTICLE VI
PREMIUM PAYMENT BENEFIT

6.1 Establishment of Premium Payment Benefit. The Premium Payment Benefit is intended to qualify under Code Section 106(a) and shall be interpreted in a manner consistent with such Code Section.

6.2 Contributions. The Participant's Premium Payment Benefit Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Payment Benefit will be equal to the amount of the Participant's Premium under the Health Care Plan. If the amount of the Participant's Premium increases or decreases, the Participant's contribution to the Premium Payment Benefit will automatically be adjusted to reflect the increase or decrease.

6.3 Decreases in Premium Payment Benefit Account. A Participant's Premium Payment Benefit will be debited for amounts applied to Health Care Plan Premiums. The Administrator will not direct the Employer to pay any Premium under the Health Care Plan to the extent such payment exceeds the balance in a Participant's Premium Payment Benefit Account.

6.4 Forfeitures. Any amount in the Premium Payment Benefit Account after the processing of all Premiums for the Plan Year will be forfeited by the Participant and the Participant will have no further claim to such amount for any reason.

ARTICLE VII
HEALTH CARE FLEXIBLE SPENDING ACCOUNT

7.1 Establishment of Health Care Flexible Spending Account. The Health Care Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and will be interpreted in a manner consistent with such Code Section and the Treasury regulations issued thereunder. Although printed within this document, the Health Care FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Section 105. The Health Care FSA is also a separate plan for purposes of the applicable provisions of ERISA, HIPAA, and COBRA.

7.2 Health Care Flexible Spending Account Participation. An Eligible Employee may elect to participate in Health Care Flexible Spending Account. A Participant in the HSA Benefit cannot participate in the Health Care FSA.

Participants who elect to participate in the Health Care Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed will be paid from amounts allocated to the Health Care Flexible Spending Account.

7.3 Contributions. For each Participant who elects to contribute to a Health Care FSA, the Administrator will establish a Health Care FSA for each Plan Year. Each Health Care FSA will contain zero dollars ($0.00) initially and at the commencement of each Plan Year. The maximum annual contribution that a Participant can make to his or her Health Care FSA will be the maximum amount allowed under Code Section 125(i), as adjusted, unless otherwise determined by the Administrator as described in the enrollment materials or Health Care FSA summary plan description, the applicable provisions of which are incorporated herein by reference. The Administrator may establish a minimum annual Health Care FSA contribution.

7.4 Decreases in Heath Care FSA. The balance in a Participant's Health Care FSA for a Plan Year will be reduced by the amount of any benefits paid to the Participant under Section 7.6.

7.5 Medical Expenses. "Medical Expenses" means expenses for medical care within the meaning of Code Section 213(d) (as modified by Code Section 106(f)) and the regulations and IRS rulings thereunder. Medical Expenses can be incurred by the Participant or his or her Spouse or Dependents.

7.6 Health Care FSA Reimbursements.

(a) *Expenses must be incurred during Plan Year.* Medical Expenses incurred by a Participant, his or her Spouse, and his or her Dependents during the Plan Year will be reimbursed subject to Section 7.6(c). Amounts that remain in a Participant's Health Care FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a grace period beginning on the first day of the subsequent Plan Year and ending no later than March 15 of such Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the Medical

Expenses, not when the Participant is formally billed or charged for, or pays for, the medical care.

(b) *Reimbursement available throughout Plan Year.* The Administrator will direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to the amount designated by the Participant for the Health Care FSA for the Plan Year. Reimbursements will be made available to the Participant throughout the Plan Year without regard to the amount of contributions made by the Participant to the Health Care FSA for the Plan Year. A Participant will be entitled to Health Care FSA reimbursements only for amounts in excess of any payments or other reimbursements from any health care plan covering the Participant, his or her Spouse, and/or Dependents for the Medical Expense. After the Participant's Health Care FSA has been exhausted for the Plan Year, claims remaining unpaid will be denied/canceled. In no event will any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) *Reimbursement Request Deadline.* The Administrator must receive the request for reimbursement for Medical Expenses on or before the June 30 following the end of the Plan Year (or such other date as may be determined by the Administrator and communicated to Participants). If a Participant fails to submit a claim within the aforementioned timeframe, those Medical Expense claims will not be eligible for reimbursement by the Plan.

(d) *Payments.* Reimbursement payments from the Health Care FSA will be made directly to the Participant. However, in the Administrator's discretion, payments from the Health Care FSA may be made directly to the service provider. The application for payment or reimbursement will be made to the Administrator on a form acceptable to the Administrator and will include such proof of claim that substantiates the Medical Expense as the Administrator deems satisfactory. The Administrator may, in its discretion, require the Participant to provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care FSA, such amount will not be claimed as a tax deduction.

(e) *Debit Cards.* The Participant may use a debit card issued to him or her by the Administrator to pay for certain eligible Medical Expenses, in accordance with the terms and conditions established by the Administrator with respect to the use of such debit card, which terms and conditions will be consistent with applicable guidance issued by the Internal Revenue Service.

(f) *Minimum Reimbursements.* The Administrator may establish a minimum reimbursement amount.

7.7 Forfeitures. The amount in a Participant's Health Care Flexible Spending Account after the processing of all claims for such Plan Year pursuant to Section 7.6 hereof will be forfeited by the Participant. In such event, the Participant will have no further claim to such amount for any reason. In addition, any Health Care FSA benefit payments that are unclaimed (*e.g.*, uncashed

benefit checks) by the last day of the Plan Year following the year in which the payment was issued will be forfeited.

7.8 Limitations on Health Care FSA Benefits. No benefits will be paid under the Health Care FSA to the extent that the expense has been submitted for reimbursement from a Participant's Dependent Care FSA or through insurance. No benefits will be paid under the Health Care FSA for medical insurance or other premiums, for cosmetic surgery or other similar procedures, or for qualified long-term care services within the meaning of Code Section 7702B(c), or as may otherwise be prohibited by applicable law.

7.9 Continuation of Health Care Coverage. To the extent required by COBRA, a qualified beneficiary (as defined in ERISA Section 607) who would lose health care coverage under the Health Care FSA upon the occurrence of a qualifying event (as described in ERISA Section 603) will be permitted to continue coverage, to the extent required by law, by electing to pay the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with Part 6 of Title I of ERISA and any regulations issued under that Part. The Employer will provide notice to each Participant of his or her rights under COBRA in accordance with applicable law and the regulations thereunder.

7.10 Qualified Medical Child Support Orders (QMCSO). The Health Care FSA will be interpreted and administered so as to provide coverage, under procedures established by the Administrator, with respect to individuals for whom coverage is required by the applicable provisions of ERISA Section 609 and any regulations under those provisions.

ARTICLE VIII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

8.1 Establishment of Dependent Care Flexible Spending Account. The Dependent Care Flexible Spending Account is intended to qualify as a dependent care assistance program under Code Section 129 and will be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Although printed within this document, the Dependent Care FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Section 129.

8.2 Dependent Care FSA Participation. Eligible Employees may elect to participate in the Dependent Care FSA for the reimbursement of Dependent Care Expenses. All amounts reimbursed will be paid from amounts allocated to the Participant's Dependent Care FSA.

8.3 Contributions. For each Participant who elects to contribute to a Dependent Care FSA, the Administrator will establish a Dependent Care FSA for each Plan Year. Each Participant's Dependent Care FSA will contain zero dollars ($0.00) initially and at the commencement of each Plan Year. The maximum annual contribution that a Participant can make to his or her Dependent Care FSA is the lesser of: (i) $5,000, or, if the Participant is married and files a separate Federal income tax return for that year, $2,500; (ii) the Participant's earned income; or (iii) the earned income of the Participant's Spouse, if applicable, unless otherwise determined by the Administrator and as described in the enrollment materials or Dependent Care FSA plan summary, the applicable provisions of which are incorporated herein by reference. Such amount shall not exceed the limit under Code Section 129, as adjusted. The Administrator may establish a minimum annual Dependent Care FSA contribution.

Each Plan Year, the University may make a discretionary taxable matching contribution to a Participant's Dependent Care FSA.

8.4 Decreases in Dependent Care FSA. The balance in a Participant's Dependent Care FSA for a Plan Year will be reduced by the amount of any benefits paid to the Participant under Section 8.6.

8.5 Dependent Care Expenses. For purposes of the Plan, a "Dependent Care Expense" means an expense paid for household services or for the care of a Qualifying Individual (as defined below) to the extent such expense is incurred to enable the Participant (and his or her Spouse, if married), to be gainfully employed for any period during which the Participant has one or more Qualifying Individuals. Notwithstanding the foregoing:

(a) Expenses incurred outside the Participant's household constitute Dependent Care Expenses only if incurred for a Qualifying Individual who is a Dependent under the age of 13 for whom the Participant is entitled to an exemption under Code Section 151 or for a Qualifying Individual who regularly spends at least eight hours a day in the Participant's household.

(b) If the expense is incurred outside the Participant's home at a facility that provides care for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable licensing requirements, if any.

(c) Dependent Care Expenses of a Participant do not include expenses paid or incurred for services provided by a child of such Participant who is under the age of 19 or an individual who is a Dependent of the Participant or the Participant's Spouse.

Whether an expense qualifies as a Dependent Care Expense shall be determined in accordance with Code Section 21(b)(2).

A "Qualifying Individual" has the meaning given to the term in Code Section 21(b)(1). Generally, a Qualifying Individual is a dependent (as defined in Code Section 152(a)(1)) of a Participant who is under the age of 13 or a Dependent or Spouse of the Participant who is physically or mentally incapably of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of such taxable year.

8.6 Dependent Care FSA Reimbursements.

(a) *Expenses must be incurred during Plan Year.* Eligible Dependent Care Expenses incurred by a Participant during the Plan Year will be reimbursed by his her or Dependent Care FSA, subject to Section 8.6(c). Amounts that remain in a Participant's Dependent Care FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a grace period beginning on the first day of the subsequent Plan Year and ending no later than March 15 of such Plan Year. Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Individuals are provided with the dependent care that gives rise to the Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care.

(b) *Reimbursement available throughout Plan Year.* The Administrator will direct the reimbursement to each eligible Participant for all allowable Dependent Care Expenses, up to the then-existing amount contained in the Participant's Dependent Care FSA at the time of the reimbursement. The Administrator may provide that any amount requested in excess of the account balance will be carried over to the following reimbursement period and processed at that time, or may require the Participant to submit a new claim for additional reimbursement. After the Participant's Dependent Care FSA has been exhausted for the Plan Year, claims remaining unpaid will be canceled. In no event will any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) *Reimbursement Request Deadline.* The Administrator must receive the request for reimbursement for Dependent Care Expenses on or before the June 30 following the end of the Plan Year (or such other date as may be determined by the Administrator and communicated to Participants). If a Participant fails to submit a claim within the aforementioned timeframes, those Dependent Care Expense claims will not be eligible for reimbursement by the Plan.

(d) *Payments.* Reimbursement payments from the Dependent Care FSA will be made directly to the Participant. The application for payment or reimbursement will be made to the Administrator on a form acceptable to the Administrator and will include such proof of claim that substantiates the Dependent Care Expenses as the Administrator deems satisfactory. The Administrator may, in its discretion, require the Participant to provide a written statement that the Dependent Care Expense has not been otherwise been reimbursed and, if reimbursed from the Dependent Care FSA, such amount will not be claimed as a tax credit or deduction.

(e) *Minimum Reimbursements.* The Administrator may establish a minimum reimbursement amount from the Dependent Care FSA.

8.7 Forfeitures. The amount in the Dependent Care FSA after the processing of all claims for the Plan Year pursuant to Section 8.6 hereof will be forfeited by the Participant. In addition, any Dependent Care FSA benefit payments that are unclaimed (*e.g.*, uncashed benefit checks) by the last day of the Plan Year following the year in which the payment was issued will be forfeited.

8.8 Limitations on Dependent Care FSA Benefits. No benefits will be paid under the Dependent Care FSA to the extent that an expense has been submitted for reimbursement from a Participant's Health Care FSA.

ARTICLE IX
HEALTH SAVINGS ACCOUNT

9.1 Establishment of Health Savings Account. The Health Savings Account is intended to qualify as a health savings account under Code Section 223 and will be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.

9.2 Health Savings Account Participation. Each Eligible Employee who participates in the eligible high-deductible health plan offered by the Employer may elect to participate in the HSA. All other employees, including those who participate in ineligible high-deductible health plans offered by the Employer, are not eligible to participate in the HSA.

9.3 HSA Contributions. The maximum annual contribution for a Plan Year shall be determined by the Administrator as described in the enrollment materials or HSA summary of benefits, the applicable provisions of which are incorporated herein by reference. The maximum annual contribution shall not exceed the statutory maximum set forth in Code Section 223(b), as adjusted for increases in accordance with Code Section 223(g), which will be reduced by any Employer contribution made to the HSA on the Participant's behalf and will be prorated for the number of months in which the Participant is eligible to contribute to an HSA. Participants who are age 55 or older may make an additional catch-up contribution to the HSA as provided in Code Section 223(b)(3).

The balance in a Participant's HSA for a Plan Year will be increased (a) each payroll period by the portion of the Participant's contributions for that Plan Year that he or she has elected to apply toward his or her HSA in accordance with Section 3.1 and (b) by the amount of contributions that the Employer has allocated to the Participant's HSA, if any.

A Participant may prospectively increase, decrease, or revoke his or her contributions to the HSA at any time during the Plan Year.

9.4 Recording Contributions for HSA. The HSA Benefit is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain a Participant's HSA. The Administrator will maintain records to keep track of HSA contributions that a Participant makes, but it will not create a separate fund or otherwise segregate assets for this purpose.

9.5 Limitations on HSA Benefits. If a Participant or his or her Spouse has elected to participate in a general purpose health flexible spending account (under this Plan or otherwise) or a health reimbursement account (HRA), the Participant is not eligible to participate in the HSA during the health FSA's or HRA's plan year, and vice versa. If the Participant has a balance on the last day of the Plan Year in his or her Health Care FSA in excess of $0.00, the Participant cannot participate in the HSA Benefit until the next following April, unless the Participant elects to forfeit the balance as of the last day of the Plan Year.

9.6 HSA Not Intended To Be An ERISA Plan. The HSA is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Although this Plan may allow pre-tax contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE X
CLAIMS PROCEDURES

10.1 General.

(a) *Initial Claims*. A request for benefits is a "claim" subject to this Article X only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. Claims must be filed in writing unless the Administrator provides otherwise. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative by providing written notice of such designation to the Administrator.

(b) *Documentation*. A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Administrator. Any such claim shall include all information and evidence that the Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format, to the extent that such alternative format is permitted under applicable law.

10.2 Health Care FSA Claims. This Section 10.2 shall apply for any claim for benefits under the Health Care Flexible Spending Account. Health Care FSA claims shall be administered in accordance with 29 CFR 2560.503-1 and the claims and appeals procedures set forth in The University of Chicago Health Care Plans, the applicable provisions of which are incorporated herein by reference.

10.3 HSA Claims. Claims relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.

10.4 Non-Health Care FSA or HSA Claims. This Section 10.4 shall apply for any claim for benefits other than those relating to the Health Care Flexible Spending Account or the HSA.

(a) *Claim Denials and Appeals*.

(i) *Timing of Notice of Denied Claim*. The Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time,

ordinarily within 90 days after receipt of the claim, unless the Administrator determines additional time is required to make a determination.

(ii) *Content of Notice of Denied Claim*. If a claim is wholly or partially denied, the Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

(iii) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Administrator on or before the 180th day after he receives the Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 90 days of receipt of the appeal, unless the Administrator determines additional time is required to make a determination.

(iv) *Denial of Appeal*. If an appeal is wholly or partially denied, the Administrator shall provide the Claimant with a notice identifying the reason or reasons for such denial. The determination rendered by the Administrator shall be binding upon all parties.

10.5 Exhaustion of Remedies; Period for Filing Suit. Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, claimants must exhaust the Plan's claim procedures. This exhaustion requirement applies to all types of claims under the Plan, including without limitation: (i) claims for and recovery of benefits under the Plan, (ii) enforcement of rights under the terms of the Plan, and (iii) clarification of rights to future benefits under the terms of the Plan. Unless otherwise provided in the Plan or required pursuant to applicable law, legal action for benefits under the Plan must be brought within one (1) year after the date of a final decision on the claim.

ARTICLE XI
ADMINISTRATION

11.1 Administration. The University will be the Administrator, unless the University appoints any other person or entity to serve as the Administrator. For purposes of those Benefits governed by ERISA, the plan administrator and named fiduciary will be the University or the person or committee appointed by the University for this purpose.

11.2 Powers of the Administrators. The operation of the Plan will be under the supervision of the Administrator. The Administrator will have full power and discretion to administer the Plan in all respects and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as will be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator will have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan, including, but not limited to:

(a) To adopt rules of procedure and regulations it determines may be necessary for the proper and efficient administration of the Plan, consistent with the provisions of the Plan.

(b) To enforce the Plan in accordance with its terms and with rules and regulations it has adopted.

(c) To determine all questions arising under the Plan, including claims for benefits, to interpret the Plan, and to remedy ambiguities, inconsistencies or omissions.

(d) To maintain adequate records concerning the Plan and its administration.

(e) To reject elections or to limit contributions or benefits for certain highly compensated Participants if it deems such action to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code.

(f) To furnish the Employer with such information with respect to the Plan as may be required for tax or other purposes.

(g) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

11.3 Delegation by the Administrator. The Administrator may allocate and delegate its responsibilities under the Plan, and designate such committees, entities, and persons to carry out any of its responsibilities under the Plan. Any such allocation or delegation will be in writing and will describe the advice to be rendered or the functions and duties to be performed by the delegate.

11.4 Uniform Rules. The Administrator will uniformly apply any rules and regulations it adopts to all persons similarly situated.

11.5 Administrator Decisions Final. To the extent permitted by law, any interpretation of the Plan and any decision on any matter within the discretion of the Administrator made by it in good faith are final and binding on all persons. A misstatement or other mistake of fact will be corrected when it becomes known, and the Administrator will make such adjustment on account thereof as it considers equitable and practicable.

11.6 Indemnification. To the extent permitted by law, the University will indemnify and hold harmless the members of the Board of Trustees and any Employee to whom any Administrator duties are allocated and delegated against any and all liabilities, losses, costs, or expenses (including legal fees and expenses) of whatsoever kind and nature that may be imposed on, incurred by, or asserted against the delegates at any time by reason of the performance of a delegated function, but only if the individual delegate did not act dishonestly or in a willful violation of the law or regulation under which such liability, loss, cost, or expense arose. Notwithstanding the foregoing, any indemnification for liabilities, costs, or expenses of whatsoever kind and nature that may be imposed on a contract administrator will be governed by and in accordance with the services contract in effect between the Employer and the contract administrator.

11.7 Expenses. The costs of the Plan will be borne by the University. For the HSA Benefit, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such HSA fees will be the sole responsibility of the Participant; they will not be paid by the University unless the University, in its discretion, otherwise elects to pay such fees.

ARTICLE XII
AMENDMENT AND TERMINATION

12.1 Amendment. The University, by action of its Board of Trustees (or an officer or employee who has been delegated authority from the Board of Trustees to perform this function), shall have the right in its sole discretion at any time, and from time to time, to amend or modify in whole or in part any of the provisions of the Plan without liability.

12.2 Termination. The University intends to continue the Plan indefinitely, but reserves the right to terminate the Plan at any time. The University, by action of its Board of Trustees, shall have the right in its sole discretion, to discontinue or terminate the Plan without liability. In the event of a Plan termination, all Plan contributions will cease. All payments from the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account for claims incurred prior to the date of termination will continue to be paid in accordance with the terms of the Plan until 90 days after the termination date of the Plan. Any amounts remaining in such accounts as of the end of the 90-day period following the date of Plan termination will be forfeited.

ARTICLE XIII
MISCELLANEOUS

13.1 No Guarantee of Employment. The adoption and maintenance of the Plan will not be deemed to be a contract of employment between the University and any Employee. Nothing contained in the Plan will give any Employee the right to be retained in the employ of the University or to interfere with the right of the University to discharge any Employee at any time, nor will it give the University the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

13.2 Limitation on Liability. The University does not guarantee benefits payable under any insurance policy or other similar contracts described or referred to in the Plan, and any benefits thereunder will be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under the policy or contract.

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

13.4 Non-Alienation. No benefit payable at any time under this Plan will be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind, and any attempt to do so will be void. No benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

13.5 Recovery of Overpayments. Whenever payments have been made in excess of the amount of payment necessary to satisfy the intent of the Plan, the Administrator will have the right, exercisable alone and in its sole discretion, to recover these excess payments. Further, the Administrator reserves the right to deduct the amount of any excess payments from future benefits to which an Employee, his or her Spouse or any of his or her Dependents may become entitled. If any Employee receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, such Employee will indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement will not exceed the amount of additional federal and state income tax (plus any penalties) that the Employee would have owed if the payments or reimbursements had been made to the Employee as regular cash compensation, plus the Employee's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

13.6 Inability to Locate Payee. If the Administrator is unable to make payments to any Participant or other person to whom a payment is due under the Plan because of an inability to ascertain the whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments that may be due to such Participant or other person will be forfeited on the last day of the Plan Year that next follows the Plan Year in which such payment first became due.

13.7 Mental or Physical Incompetency. If the Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, the Administrator may cause all payments thereafter becoming due to such person to be made to any other person for his benefit determined to be appropriate in the Administrator's sole discretion. Payments made pursuant to this Section 13.7 will completely discharge the Administrator and Employer from further liability hereunder.

13.8 Payment Upon Death. Any benefit payable under the Plan after the death of a Participant will be paid to any surviving Spouse or, if no Spouse, to the Participant's estate. If there is doubt as to the right of any beneficiary to receive any amount, the Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon, or it may pay such amount into any court of appropriate jurisdiction, in either of which events neither the Administrator nor any Employer will be under any further liability to any person.

13.9 Requirement for Proper Forms. All communications and elections in connection with the Plan made by an Employee or other person will become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Administrator.

13.10 Tax Effects. Neither the University nor the Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Participant hereunder will be treated as excludable from gross income for state or federal income tax purposes.

13.11 Headings. The headings contained herein are for convenience and reference only, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way will affect the Plan or the construction of any provision thereof.

13.12 Severability. Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof will be given effect to the maximum extent possible.

13.13 Applicable Law. The Plan and all rights under the Plan will be governed by and construed according to the laws of the State of Illinois, except to the extent preempted by Federal Law.

13.14 Participating Employers. Any Affiliated Employer may, with the consent of the University, adopt the Plan and become a "Participating Employer" hereunder. The entities listed in Appendix B attached hereto will each be a Participating Employer under the Plan.

13.15 HIPAA. Certain Benefits under the Plan are subject to the Privacy Rule and Security Rule requirements under HIPAA. The Benefits subject to such rules are identified in Appendix A to the Plan. The Privacy rules requirements under HIPAA set forth in Appendix A are effective as of April 14, 2004 for each benefit subject to such requirements and the Security Rule requirements under HIPAA set forth in Appendix A are effective as of April 20, 2005 for each Benefit subject to such requirements.

In witness whereof, the University has caused this Plan to be executed on this 1st day of December, 2020.

THE UNIVERSITY OF CHICAGO

By: _____

Its: Vice President and Chief Financial Officer

APPENDIX A
HIPAA PROVISIONS

This Appendix A will apply only to the Health Care Flexible Spending Account (Health Care FSA) under the Plan. This Appendix A is intended to bring the Health Care Flexible Spending Account into compliance with (i) the applicable provisions of the privacy rules set forth in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the implementing regulations thereunder (collectively, the "HIPAA Privacy Rules"), and (ii) the applicable provisions of the security standards set forth in HIPAA and the implementing regulations thereunder (collectively, the "HIPAA Security Rules"), by establishing the extent to which the Employer will receive, use and/or disclose Protected Health Information in connection with any Component Benefit Program subject to the HIPAA Privacy Rules or the HIPAA Security Rules.

1. Definitions. For purposes of this Appendix, the following definitions, in addition to those set forth above or in the Plan, will apply:

    (a) "Disclose" or "Disclosures" mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

    (b) "Health Care" means care, services, or supplies related to the health of an individual, including, without limitation:

        A. preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, and counseling, service, assessment or procedure with respect to the physical or mental condition, or functional status, of an individual, or that affects the structure or function of the body; and

        B. the sale or dispensing of a drug, device, equipment or other item in accordance with a prescription.

    (c) "Health Care Clearing House" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:

        (1) processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a Standard Transaction; or

        (2) receives a Standard Transaction from another entity and processes or facilitates the processing of Health Information into nonstandard format or nonstandard data content for the receiving entity.

    (d) "Health Care Operations" has the meaning set forth in 45 C.F.R. § 164.501.

(e) "Health Care Provider" means a provider of services as defined in 42 U.S.C. § 1395x(u), a provider of medical or health services as defined in 42 U.S.C. § 1395x(s), and any person or organization who furnishes, bills, or is paid for Health Care in the normal course of business.

(f) "Health Information" means any information, including genetic information, whether oral or recorded in any form or medium, that:

(1) is created or received by a Health Care Provider, health plan, public health authority employer, life insurer, school or university, or Health Care Clearing House; and

(2) relates to the past, present or future physical or mental health or condition of an individual, the provision of Health Care to any individual, or the past, present, or future payment for the provision of Health Care to an individual.

(g) "Individually Identifiable Health Information" means information that is a subset of Health Information, including demographic information, collected from an individual that:

(1) is created or received by a Health Care Provider, health plan (including the Health Care FSA), the Employer or a Health Care Clearing House; and

(2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of Health Care to an individual; and

(A) that identifies the individual, or

(B) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(h) "Health Care FSA Administration Functions" means administration functions performed by the Employer or any other affiliated employer on behalf of the Health Care Flexible Spending Account, and excludes functions performed by the Employer or any other affiliated employer in connection with any other benefit or benefit plan of the Employer or any other affiliated employer.

(i) "Protected Health Information" means Individually Identifiable Health Information that is either transmitted by electronic media; maintained in any medium as described in the definition of "electronic media" as set forth in 45 C.F.R. § 162.103; or transmitted or maintained in any other form or medium. Notwithstanding the foregoing, Protected Health Information will not include Individually Identifiable Health Information in education records covered by the Family Educational Right and Privacy Act, and records described in 20 U.S.C. § 1231g(a)(4)(B)(iv).

(j) "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(k) "Standard Transaction" means a transaction described in Section 1173(a)(1) of the Social Security Act.

(l) "Summary Health Information" means information, including, without limitation, Individually Identifiable Health Information, that:

(1) summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an Employer has provided health benefits under a group health plan; and

(2) from which the information described in 45 C.F.R. § 164.514(b)(2)(i) has been deleted; provided, however, that notwithstanding the foregoing, the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

Any terms used but not otherwise defined herein will have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, 164.304 or 164.501.

2. Disclosure of Summary Health Information. The Health Care FSA may Disclose Summary Health Information to the Employer only if the Employer requests the Summary Health Information for the purpose of modifying, amending or terminating the Health Care FSA.

3. Disclosure of Enrollment Information. The Health Care FSA may Disclose to the Employer information on whether the individual is participating in the Health Care FSA.

4. Use or Disclosure of Protected Health Information. With respect to Protected Health Information, the Health Care FSA will:

(a) establish the permitted and required uses and Disclosures of such information by or to the Employer, which are consistent with the HIPAA Privacy Rules and 45 C.F.R. § 164.504(f); and

(b) Disclose Protected Health Information to the Employer only upon certification by the Employer that this Health Care FSA has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii).

5. Procedures. With respect to Protected Health Information, the Employer will:

(a) Not use or further Disclose the information other than as permitted or required by the plan document for the Health Care FSA or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Employer provides Protected Health Information received from the Health Care FSA agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or Disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Health Care FSA any use or Disclosure of the information of which the Employer becomes aware that is inconsistent with the uses or Disclosures provided for in this Appendix A;

(e) Make an individual's Protected Health Information available to him or her in accordance with 45 C.F.R. § 164.524;

(f) Make an individual's Protected Health Information available to him or her for amendment by the individual, and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

(g) Make available to the Health Care FSA the information required to provide an accounting of Disclosures in accordance with 45 C.F.R. § 164.528;

(h) Make its internal practices, books, and records relating to the use and Disclosure of Protected Health Information received from the Health Care FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Care FSA with the HIPAA Privacy Rules;

(i) If feasible, return or destroy all Protected Health Information received from the Health Care FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which Disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit the further uses and Disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure that the adequate separation required in 45 C.F.R. § 164.504(f)(2)(iii) is established.

6. Separation Between the Health Care FSA and the Employer.

(a) In accordance with 45 C.F.R. § 164.504(f)(2)(iii), this paragraph describes those employees or classes of employees or other persons under the control of the Employer to be given access to the Protected Health Information to be Disclosed. Any employee or person who receives Protected Health Information relating to payment under, Health Care Operations of, or other matters pertaining to the Health Care FSA in the ordinary course of business will be included in this description. The following employees, or classes of employees, will be provided such access:

employees of the Human Resources, IT and Legal Departments of the Employer. The Employer will limit such individuals' access to Protected Health Information to the minimum reasonably necessary for such purposes.

(b) In accordance with 45 C.F.R. § 164.504(f)(2)(iii), the access to and use by such employees and other persons described in paragraph (a) above will be restricted to the Health Care FSA Administration Functions that the Employer or any other affiliated employer performs for the Health Care FSA.

(c) In accordance with 45 C.F.R. § 164.504(f)(2)(iii), the Health Care FSA will adopt sanction procedures that provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (a) above with the provisions of this Section 6. The Employer will promptly report any breach, violation or noncompliance to the Health Care FSA and will cooperate with the Health Care FSA to correct the breach, violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the breach, violation or noncompliance.

7. Specific Uses and Disclosures. The Health Care FSA may:

(a) Disclose Protected Health Information to the Employer to carry out Health Care FSA Administration Functions that the Employer or any other affiliated employer performs only consistent with the provisions of Section 6 above;

(b) Not Disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer; and

(c) Not Disclose Protected Health Information to the Employer as otherwise permitted by this Section, unless the Health Care FSA gives the individual written notice required by 45 C.F.R. § 164.520(b) that includes a separate statement that the Health Care FSA may Disclose Protected Health Information to the Employer.

8. Health Care FSA Administration Functions. The Employer may use the Protected Health Information for the following Health Care FSA Administration Functions:

(a) payment; and

(b) Health Care Operations, such as quality assurance, claims processing, auditing, monitoring and management of carve-out plans such as vision or dental plans.

9. Electronic Protected Health Information Standards. The Employer agrees to:

(a) implement administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic

Protected Health Information that the Employer creates, receives, maintains or transmits on behalf of the Health Care FSA;

(b) ensure that any agent, including a subcontractor, to whom the Employer provides such electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect such electronic Protected Health Information;

(c) report to the Health Care FSA, in writing, any Security Incident of which the Employer becomes aware; and

(d) ensure the provisions of Section 6 above are supported by reasonable and appropriate security measures.

10. Certification by the Employer. The Employer has certified that the Plan has been adopted to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii) and that the Employer agrees to all of the conditions set forth in this Appendix A.

APPENDIX B
PARTICIPATING EMPLOYERS

None.

APPENDIX C
SPECIAL PLAN PROVISIONS

Notwithstanding anything in the Plan to the contrary, the following provisions govern:

I. Special Health Care FSA and Dependent Care FSA Elections During 2020 Plan Year. During the period beginning April 1, 2020 and ending December 31, 2020 (the "2002 Plan Year"), a Participant may, with respect to the remainder of the 2020 Plan Year, make one election not otherwise permitted by the Plan to increase or decrease an election under the Health Care FSA and one election not otherwise permitted by the Plan to increase or decrease an election under the Dependent Care FSA, in accordance with IRS Notice 2020-29. Any such election to decrease cannot: (1) result in an allocation of Plan amounts to a Health Care FSA or Dependent Care FSA that is less than the amount already reimbursed from the Participant's Health Care FSA or Dependent Care FSA, as applicable, or (2) be less than the amount already contributed to the Health Care FSA or Dependent Care FSA, as applicable. This provision shall not be construed to permit an Employee to enroll in the Health Care FSA or Dependent Care FSA if not otherwise eligible under another section of the Plan.

II. Health Care FSA 2020 Grace Period. For Participants who do not participate in the HSA for the 2020 Plan Year, amounts that remain in a Participant's Health Care FSA at the end of the 2019 Plan Year may be used to reimburse Medical Expenses that are incurred during a grace period beginning on January 1, 2020 and ending no later than December 31, 2020.

III. 2020 Health Care FSA Reimbursement Request Deadline. For Participants who do not participate in the HSA Benefit for the 2020 Plan Year, the Administrator must receive a request for a Heath Care FSA reimbursement of Medical Expenses incurred during the 2019 Plan Year on or before December 31, 2020.

IV. Dependent Care FSA Grace Period. Unused amounts that remain in a Participant's Dependent Care FSA at the end of the 2019 Plan Year may be used to reimburse expense that are incurred during a grace period beginning on January 1, 2020 and ending no later than December 31, 2020.

V. 2020 Dependent Care FSA Reimbursement Request Deadline. The Administrator must receive a request for Dependent Care FSA reimbursement of Dependent Care Expenses incurred during the 2019 Plan Year on or before December 31, 2020.