

EXECUTION COPY

UNIVERSITY OF CALIFORNIA

SECTION 125 PLAN

(Amended and Restated Effective as of January 1, 2014)

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THE UNIVERSITY OF CALIFORNIA

SECTION 125 PLAN

(Amended and Restated Effective as of January 1, 2014)

INTRODUCTION

The University of California has adopted this amended and restated University of California Section 125 Plan effective January 1, 2014. The Plan was established to provide Eligible Employees of the Employer the opportunity to choose between cash and the payment on a pre-tax basis for the cost of certain Optional Benefits. Provisions may vary among different Eligible Employee groups, as set forth in the University of California Group Insurance Regulations and applicable Summary Plan Descriptions, and eligibility and terms may vary as set forth in applicable collective bargaining agreements.

The University of California Section 125 Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, (the “Code”) and the Treasury Regulations thereunder. The Tax Savings on Insurance Premiums Plan, a “premium conversion plan” under Section 125 of the Code, is set forth in Appendix A. The Health Flexible Spending Account Plan, intended to qualify as an “accident or health plan” and a “self-funded medical reimbursement plan” under Section 105 of the Code, is set forth in Appendix B. The Dependent Care Spending Account Plan, intended to qualify as a “dependent care assistance program” under Section 129 of the Code, is set forth in Appendix C. The Health Savings Account, intended to qualify as a “health savings account” within the meaning of Section 223 of the Code, is set forth in Appendix D. Appendices A, B, C and D are hereby incorporated by reference.

ARTICLE 1

DEFINITIONS

- 1.1 Benefit Program means one of the employee benefit programs maintained by the Employer through group plans, insurance policy(ies) and contract(s) that are referenced in the Plan.
- 1.2 COBRA means the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, as set forth in the Public Health Service Act.
- 1.3 Code means the Internal Revenue Code of 1986, as amended.
- 1.4 Compensation means with respect to any pay period, the total cash remuneration received or which would have been received by the Participant from the Employer during the coverage period prior to any employee contributions authorized under the Plan.
- 1.5 Default Coverage means the Optional Benefits that an Eligible Employee will be deemed to have elected if he or she failed to make an affirmative Optional Benefits election.
- 1.6 Domestic Partner means an individual who meets and continues to meet all of the criteria set forth in the GIRs for status as a Participant's domestic partner for purposes of eligibility for participation in the University's health and welfare plans.
- 1.7 Effective Date means the effective date of the amended and restated Plan, which is January 1, 2014.
- 1.8 Employer Contributions means the amount, if any, that is allocated to each Eligible Employee who elects one or more Optional Benefits. The amount of any Employer Contributions allocated to each Eligible Employee for use in a Plan Year is determined by the Employer and may change from year to year.
- 1.9 Eligible Employee means an Employee who is eligible to elect one or more Optional Benefits in accordance with the provisions set forth in the GIRs and the applicable Summary Plan Descriptions.
- 1.10 Employee means any individual who is employed as a common law employee of the Employer and who is on the Employer's Payroll. The term "Employee" does not include:
 - (a) an individual who is not classified by the University, in its sole discretion, as an employee under Section 3121(d) of the Code (including but not limited to an individual classified by the University as an independent contractor or independent consultant or non-employee consultant);
 - (b) an individual who is classified by the University, in its sole discretion, as an employee of an entity other than the University.

An individual described in 1.10 (a) or (b), above shall not meet the definition of Eligible Employee, and shall be ineligible to participate in the Plan, even if the classification is subsequently determined to be erroneous or is retroactively revised. For purposes of the preceding sentence, an individual shall be treated as “not classified as an employee,” for any period if the payments to that individual by the University for services are not initially treated by the University as subject to the federal tax withholding and tax reporting obligations that apply to payments of “wages” to employees under Section 3121(d) of the Code.

- 1.11 Employer or University means the University of California, a public trust and a public corporation of the State of California. References to Employer or to the University shall include its affiliate, Hastings College of the Law, unless the context clearly indicates otherwise.
- 1.12 Family Member means any adult or child who qualifies as a “family member” under the terms of the GIRs.
- 1.13 FMLA Leave means a leave that is granted to a Participant who meets the requirements for such leave under the Family and Medical Leave Act of 1993, as amended (FMLA) for any of the following reasons:
 - (a) to care for the Employee’s child after birth, or placement for adoption or foster care;
 - (b) to care for the Employee’s Spouse, or for the Employee’s Domestic Partner, son or daughter or parent, who has a serious health condition;
 - (c) for a serious health condition that makes the Employee unable to perform his or her job;
 - (d) because of a “qualifying exigency” (as defined by the FMLA) arising because an Employee’s Spouse or Domestic Partner, son, daughter or parent is on covered active duty (or called to active duty status) in the armed forces; or
 - (e) to care for a “covered servicemember” (as defined by the FMLA) with a serious injury or illness if the Employee is the Spouse or Domestic Partner, son, daughter, parent, or next of kin of the servicemember.
- 1.14 GIRs means the University of California Group Insurance Regulations and accompanying Administrative Supplements.
- 1.15 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.
- 1.16 Highly Compensated Employee means any person who is a highly compensated Participant or highly compensated individual as defined in Section 125 of the Code.

- 1.17 Non-Highly Compensated Employee means any person who is not classified as a Highly Compensated Employee.
- 1.18 Open Enrollment Period means the period of time (as determined by the Employer) during which elections for the following Plan Year are made.
- 1.19 Optional Benefits means those benefits made available by the Employer to its Eligible Employees. These benefits include the following:

Optional Benefits as of January 1, 2014	Funding
Group Medical Plan	Pre-Tax Contributions under Tax Savings on Insurance Premiums Plan – Appendix A
Health Flexible Spending Account Plan – Appendix B	Pre-Tax Contributions
Dependent Care Flexible Spending Account – Appendix C	Pre-Tax Contributions
Health Savings Account – Appendix D	Pre-Tax Contributions

- 1.20 Participant means any Eligible Employee or former Eligible Employee who participates in the Plan.
- 1.21 Payroll means the system used by the Employer to pay those individuals it regards as its common law employees for their services and to withhold employment taxes from the compensation it pays to such common law employees. “Payroll” does not include any system the Employer uses to pay individuals whom it does not regard as its common law employees and for whom it does not actually withhold employment taxes (including, but not limited to, individuals it regards as independent contractors) for their services.
- 1.22 Plan or Section 125 Plan means this amended and restated University of California Section 125 Plan.
- 1.23 Plan Administrator means the President of the University, and the person or persons designated by the President as being responsible for the operations and administration of the Plan, or the authorized delegate(s) of such person or persons.
- 1.24 Plan Sponsor means the University of California.
- 1.25 Plan Year means each calendar year that begins on January 1 and ends on December 31st.
- 1.26 Pre-Tax Contributions means any amount withheld from an Eligible Employee’s Compensation pursuant to an actual or deemed Salary Reduction Agreement so that the Eligible Employee can elect Optional Benefits that are Qualified Benefits.

- 1.27 Qualified Benefits means benefits excluded from an Eligible Employee's taxable income under Section 125(f) of the Code.
- 1.28 Salary Reduction Agreement means the actual or deemed agreement, made by an Eligible Employee, under which the Employee will pay through payroll deduction for Optional Benefits.
- 1.30 Spouse means the individual to whom a Participant is legally married.
- 1.29 Summary Plan Description means the summary plan description, benefit booklet and/or Open Enrollment Period materials published by or for the Employer with respect to one or more Benefit Programs or Optional Benefits.

ARTICLE 2

ELIGIBILITY

2.1 Participation. Each Eligible Employee shall be eligible to make elections under the Plan (or to receive Default Coverage in the absence of a timely election) as set forth in Section 2.2, below.

2.2 Timing for Eligible Employees to Elect Participation.

(a) General Rule. The specific rules regarding the time periods for making an election under the Plan are set forth in the GIRs.

(b) Default Coverage. An Eligible Employee who has Default Coverage during the Plan Year is not permitted to make additional elections under the Plan, unless required by applicable law or permitted under Section 3.7 or the terms of an Appendix.

(c) Former Participant. If a former Participant who terminated employment or otherwise ceased to be an Eligible Employee is rehired or returned to status as an Eligible Employee in less than 120 days and in the same Plan Year in which he or she terminates or otherwise ceases to be an Eligible Employee, such former Participant shall be automatically reinstated to his or her prior election under the Plan for the remainder of the Plan Year.

If a former Participant is rehired or returned to status as an Eligible Employee after 120 days or more or in a new Plan Year, he or she will again become eligible to make a new election for the remainder of the same or new Plan Year, as applicable.

2.3 Termination of Participation. A Participant's participation in the Plan shall terminate on the earliest of:

(a) The last day of the month in which a Participant ceases to be an Employee;

(b) The last day of the month in which the Participant ceases to be an Eligible Employee; and

(c) The date on which the Plan is terminated or amended to exclude the Participant.

2.4 Participation During FMLA Leave. If a Participant with coverage under an Optional Benefit that provides health care coverage goes on FMLA Leave, the Employer will continue to maintain such coverage on the same terms and conditions as though the Participant were an active Participant. The Employer will continue to pay its share of the premiums to the extent the Participant decides to continue coverage. If the Participant chooses to continue coverage, the Participant may pay his or her share of the premium(s) with after-tax dollars during his or her leave in a manner prescribed by the Employer.

Upon return from FMLA Leave, the Eligible Employee shall be entitled to reinstatement in the Plan as may be required under FMLA or other applicable law.

- 2.5 Participation During Non-FMLA Leave. If a Participant goes on approved non-FMLA Leave, the Employer may reduce the Participant's salary reduction contributions to zero and then resume salary reduction contributions when the leave ends as long as the commencement and termination of the leave are consistent with the change in status rules under Section 3.7. During such leave, the Participant may continue his or her coverage under an Optional Benefit that provides health care coverage by paying the full premium(s) with after-tax dollars in a manner prescribed by the Employer.

Termination of contributions on behalf of the Participant at the end of the non-FMLA leave may constitute a COBRA qualifying event for Optional Benefits subject to COBRA.

If an Eligible Employee does not participate in an Optional Benefit during non-FMLA leave, he or she may not be reimbursed for expenses incurred during such leave.

ARTICLE 3

BENEFIT ELECTIONS

- 3.1 Election of Benefits. During the Open Enrollment Period, an Eligible Employee may elect, for the following Plan Year, between cash and Pre-Tax Contributions to pay his or her share of the cost of any Optional Benefits available under the Plan. Such election must be made by following the procedures established by the Plan Administrator but in no event may an Eligible Employee make elections on or after the date on which the cash that the Eligible Employee could otherwise receive is made available to him or her.
- 3.2 Initial Election Period for Currently Eligible Employees. Each Participant or Eligible Employee must select Optional Benefits and enter into a Salary Reduction Agreement in the time and manner established by the Plan Administrator and as communicated to Eligible Employees.
- 3.3 New Employees. A newly hired Eligible Employee may elect, for the current Plan Year, between cash and any Optional Benefits under the Plan by following the procedures established by the Plan Administrator. Elections made by newly hired Employees who are eligible to participate upon their date of hire will be effective as of the Employee's date of hire, provided the Eligible Employee makes such election within 31 days after his or her date of hire or as otherwise set forth in the GIRs; except that elections to participate in the Health Flexible Spending Account Plan and/or the Dependent Care Flexible Spending Account Plan will be effective as of the first of the month following the election or as soon as administratively feasible following the first of such month, if so required by payroll deadlines. Pre-Tax Contributions used to pay for such an election will be deducted from Compensation not yet currently available on the date of election.
- 3.4 Employees Not Eligible to Participate on the Effective Date. An Employee who is not covered by Section 3.3 and who becomes eligible to become a Participant in the Plan after the Effective Date must follow procedures established by the Plan Administrator to select Optional Benefits and to enter into a Salary Reduction Agreement.
- 3.5 Benefits for Employees Who Fail to Make an Election. The applicable Summary Plan Description will describe Optional Benefits that an Eligible Employee will be deemed to have elected if the Employee fails to make an affirmative Optional Benefits election.
- 3.6 Changes by Plan Administrator. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement or any limitation on benefits imposed on Highly Compensated Employees or other groups of Eligible Employees, the Plan Administrator shall take such action as the Plan Administrator deems legal and appropriate, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or other groups of Eligible Employees, now or hereinafter as provided in the Code, without the consent of such Eligible Employees.

3.7 Irrevocability of Election. Elections made under the Plan (or deemed to be made under Section 3.5) shall be irrevocable by the Participant during the Plan Year, except as provided in this Section 3.7. Elections made or deemed to be made under the Plan for any Plan Year may not be changed or revoked after the first payroll period to which they apply, except upon the occurrence of the permitted election change events specified below. A Participant may modify a benefit election for the balance of a Plan Year and file a new election only as provided in paragraphs (a) through (e) below. The Participant must notify the Employer within 31 days of the event giving rise to a change in order to revoke his or her elections and make a new election (60 days in the case of paragraph (a)(iii), below). This section does not apply to the Health Savings Account. See Appendix C for the election change rules for the Health Savings Account.

(a) Special Enrollment Rights. A Participant may revoke his or her group medical plan coverage election and make a new election as described in, and in accordance with the terms of, Section 9801(f) of the Code. A special enrollment right will arise in the following circumstances:

(i) Involuntary Loss of Coverage. a Participant and/or his or her Family Member(s) declined enrollment in group medical plan coverage because the Participant and/or Family Member(s) had other coverage, and eligibility for such coverage is subsequently lost because (A) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (B) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage was terminated.

(ii) New Family Member. a new Family Member is acquired as a result of marriage, domestic partnership, birth, adoption, or placement for adoption;

(iii) Children's Health Insurance Program ("CHIP") or Medicaid. (A) the Participant's or Family Member's coverage under a Medicaid plan or state CHIP is terminated as a result of loss of eligibility for such coverage; or (B) the Participant or Family Member becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state CHIP with respect to coverage under the group medical plan.

(b) Change in Status Events. A Participant may revoke his or her elections and make a new election if the Participant incurs a change in family or employment status as described below. A change in family status means a change in eligible Family Members under the Plan. The revocation and new election must be on account of and correspond with a change in family status that affects coverage under the Qualified Benefits offered as Optional Benefits under the Plan.

(i) Marital Status or Status as a Domestic Partner. An event that changes a Participant's legal marital status or status as a Domestic Partner, including marriage or establishment of a domestic partnership, death of a Spouse or

Domestic Partner, divorce or termination of a domestic partnership, legal separation, or annulment.

- (ii) Number of Children. An event that changes the number of a Participant's eligible Family Members who are children, including birth, death, adoption, or placement for adoption.
 - (iii) Employment Status. Any of the following events that change the employment status of a Participant, or of a Participant's eligible Family Member: a termination or commencement of employment; a strike or lockout; a commencement of or a return from an unpaid leave of absence; a change in worksite; or a change in the employment status of an Employee or an Employee's Family Member such that the Employee or Family Member becomes (or ceases to be) eligible for the Plan or an Optional Benefit under the Plan.
 - (iv) Child Satisfies or Ceases to Satisfy Eligibility Requirements. An event that causes a child to become, or to cease to be, an eligible Family Member; for example, on account of attainment of the maximum age for coverage under an Optional Benefit.
- (c) Judgment, Decree, or Order. A judgment, decree, or order resulting from a divorce, dissolution of a domestic partnership, legal separation, annulment or change in legal custody (including a National Medical Support Notice as defined in Sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998) that either: (i) requires a Participant to provide accident or health coverage under a plan to which the Plan applies for a Participant's eligible child who is the Participant's dependent (as defined in Section 152 of the Code); or (ii) requires the Participant's Spouse or Domestic Partner, former Spouse or Domestic Partner or another individual to provide accident or health coverage for such child.
- (d) Entitlement to Medicare or Medicaid. If a Participant or the Participant's Family Member who is enrolled in an accident or health plan to which the Plan applies becomes enrolled under Medicare Part A or Part B, or in Medicaid, the Participant may make a prospective election change to cancel or reduce coverage for the individual who becomes enrolled in Medicare or Medicaid. If a Participant or the Participant's Family Member who has been enrolled in Medicare or Medicaid loses eligibility for such coverage, a Participant may make a prospective election to commence or increase coverage under an accident or health plan to which the Plan applies for the individual who lost coverage under Medicare or Medicaid.
- (e) Significant Changes in Cost or Coverage. A Participant may make an election change as a result of significant changes in cost or coverage in accordance with the rules set forth in Treasury Regulation Section 1.125-4(f). This subsection (e) shall not apply to the Health FSA Plan.

- 3.8 Effective Date of New Elections. Any modification and/or new election under the Plan shall be effective on the date as determined, and communicated to Participants, by the Plan Administrator. The new election shall not be effective earlier than the first pay period beginning after the Participant has completed the procedures to make the new elections and prior to the time the Compensation is deemed received under the Code.
- 3.9 Discretion to Permit Revocation of Elections. The determination whether (a) a Participant has incurred an event described in Section 3.7, (b) a Participant has separated from service, and (c) a significant change in cost or coverage has occurred is in the sole discretion of the Plan Administrator. The Plan Administrator's determination is conclusive and binding on all persons.
- 3.10 Termination of Election. If a Participant fails to pay his or her share of the cost of any Optional Benefit that he or she has elected (or is deemed to have elected), his or her Optional Benefit elections may be revoked and the Participant may be limited in making a new Optional Benefit election for the remainder of the Plan Year (except if, and to the extent, the Participant was on a FMLA Leave or other approved leave, or was affected by other circumstances, that permit suspension of payments, in which case he or she may be entitled to reinstatement in the Plan as may be required under FMLA, other applicable law, or University of California policy).

ARTICLE 4

FUNDING AND COST OF OPTIONAL BENEFITS

- 4.1 Source of Funding Optional Benefits. The cost of coverage under the Optional Benefits that are Qualified Benefits may, as determined by the Employer in its sole discretion, be funded by Pre-Tax Contributions and contributions made by the Employer (if any).
- 4.2 Cost of Optional Benefits. The Eligible Employee cost of each Optional Benefit, as determined by the Employer in its sole discretion or as provided under an applicable collective bargaining agreement, will be communicated to Eligible Employees in written enrollment materials and/or in information posted on the University of California Human Resources website.
- 4.3 Participant Salary Reduction. Based on the cost and the Optional Benefits that the Participant has elected under Article 3, the Employer shall withhold Pre-Tax Contributions from a Participant's Compensation in an amount equal to the Participant's share of the cost of the Optional Benefit elected or, for the Health Savings Account, the amount of the Participant's contribution.

ARTICLE 5

ADMINISTRATION OF THE PLAN

- 5.1 Plan Administration. The administrative provisions set forth in Section B of the Preface to the GIRs shall apply to the administration and operation of the Plan.

Any question or claim for benefits which arises under the terms of one of the Benefit Programs shall not be subject to review under the Plan, except as provided in Section 7.1. Such questions and claims shall instead be reviewed and decided under the terms of the appropriate provisions, if any, of such Benefit Programs or their Summary Plan Descriptions.

- 5.2 Reliance on Tables, Etc. In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Benefit Programs or by accountants, actuaries, counsel or other experts employed or engaged by the Plan Administrator.

ARTICLE 6

AMENDMENT AND TERMINATION

6.1 Amendment.

- (a) Except as may be provided in an applicable collective bargaining agreement, the President or, to the extent authorized by the President, his or her delegate, has the right, in his or her absolute discretion to amend this document by a written instrument setting forth such amendment.. Such amendment shall be effective immediately unless otherwise specified therein.
- (b) The right to amend set forth in subsection 6.1(a) is subject to any legally enforceable restrictions on amendment otherwise applicable to the Plan.

6.2 Termination.

- (a) Except as may be provided in an applicable collective bargaining agreement, the President or, to the extent authorized by the President, his or her delegate, has the right, in her absolute discretion, to terminate the Plan, in any respect and at any time, by a written instrument reciting such termination. Such termination shall be effective immediately unless otherwise specified therein.
- (b) The right to terminate set forth in subsection 6.2(a) is subject to any legally enforceable restrictions on termination otherwise applicable to the Plan.

ARTICLE 7

PROCEDURES FOR DETERMINING ELIGIBILITY DISPUTES AND BENEFIT CLAIM PROCEDURES

7.1 Procedures for Eligibility Disputes and Benefit Claim Procedures.

- (a) Eligibility Claim Procedures. If an individual is denied a benefit based on a determination that the individual is not eligible for participation in the Plan, the individual must follow the eligibility claims procedures set forth in Section D of the Preface to the GIRs.
- (b) Benefit Claim Procedures. The procedure for making claims for benefits and appealing denials of claims for benefits under a Benefit Program shall be as set forth in the first paragraph of Section D of the GIRs and in the relevant Benefit Program document or Summary Plan Description.

ARTICLE 8

MISCELLANEOUS

- 8.1 Incapacity. If, in the opinion of the Plan Administrator, any Participant becomes unable to handle properly any amounts payable to such Participant under the Plan, the Plan Administrator may make any arrangement for payment on such Participant's behalf that it determines will be beneficial to such person, including payment to such Participant's guardian, conservator, or Family Member, and such payment shall fully discharge the amounts owed to the Participant under the Plan.
- 8.2 No Contract of Employment. The Plan shall not be deemed to be a contract between the Employer and any person or to be consideration or inducement for the employment of any Employee. No Participant in the Plan shall acquire any right to be retained in the Employer's employ by virtue of the Plan, nor affect the right of the Employer to terminate the employment of a Participant at any time with or without cause, except to the extent prohibited by applicable law. Upon any Employee's dismissal or voluntary termination of employment, he shall not have any right or interest in the Plan other than as specifically provided in the Plan.
- 8.3 Inalienability. Unless otherwise provided in the Plan, in no event may any Participant, Family Member or Dependent sell, transfer, anticipate, assign, hypothecate or otherwise dispose of any right or interest under the Plan. At no time shall any right or interest under the Plan be subject to the claims of creditors nor liable to attachment, execution or other legal process.
- 8.4 Addresses. Each Participant must file with the Plan his or her address and any change of address. Any communication addressed to such Participant at the last address as so filed shall be binding upon the Participant for all purposes of the Plan, and the Plan, the Plan Administrator, and the Employer shall not be obligated to ascertain the whereabouts of any Participant.
- 8.5 Requirement to Furnish Information. Participants shall provide the Employer and the Plan Administrator with such information and evidence and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
- 8.6 Titles and Headings. The titles and headings of the articles, sections and subsections of this instrument appear for convenience of reference only, and in the case of any conflicts, the text of this instrument, rather than the titles or headings, shall control.
- 8.7 Separate Plans. To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of Code Section 105(h), each coverage level, each group of Employees or former Employees covered by the Plan, and each class of benefits provided under the Plan will constitute a separate "plan."

8.8 Represented Employees. Some or all of the provisions of the Plan may not apply to Employees who are members of certain exclusively represented collective bargaining units.

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

By: _____

Dwaine B. Duckett
Vice President, Human Resources

Date: December _____, 2013

APPENDIX A

TAX SAVINGS ON INSURANCE PREMIUMS PLAN

ARTICLE 1

PURPOSE OF THE PLAN

- 1.1 Introduction. The Tax Savings on Insurance Premium Plan (the “TIPS Plan”) is a premium conversion plan. The purpose of the TIPS Plan is to enable Participants to pay for their share of the cost of coverage under the Group Medical Plan Optional Benefit on a pre-tax basis.

ARTICLE 2

DEFINITIONS

- 2.1 Terms. Capitalized terms shall have the same meaning given to them in the Section 125 Plan.

ARTICLE 3

PARTICIPATION

- 3.1 Eligibility. The general eligibility provisions are set forth in Section 2.1 of the Section 125 Plan.
- 3.2 Termination of Participation. An Eligible Employee’s participation shall terminate in accordance with Section 2.3 of the Section 125 Plan.

ARTICLE 4

ELECTIONS

- 4.1 Election Procedure. Each Eligible Employee may elect between cash and Pre-Tax Contributions in order to fund his or her share of the cost of coverage under the Group Medical Plan Optional Benefit. The election procedures are set forth in Article 3 of the Section 125 Plan.

ARTICLE 5

ADMINISTRATION

- 5.1 All Articles of the Section 125 Plan apply to this Appendix A and are hereby incorporated by reference.

APPENDIX B

HEALTH FLEXIBLE SPENDING ACCOUNT PLAN

ARTICLE 1

PURPOSE OF THE PLAN

- 1.1 Introduction. The purpose of the Health Flexible Spending Account Plan (the “Health FSA Plan”) is to enable Eligible Employees to contribute to the Health FSA Optional Benefit on a pre-tax basis and to receive reimbursement for Qualifying Medical Expenses. To participate in the Health FSA Plan, an Eligible Employee must elect to contribute a minimum of \$180 per Plan Year.

ARTICLE 2

DEFINITIONS

Capitalized terms shall have the same meaning given to them in the Section 125 Plan. Whenever used in this Appendix B, the following terms have the following meanings unless a different meaning is clearly required by the context:

- 2.1 Claims Administrator means the Plan Administrator or such other entity as designated in writing by the Employer and/or Plan Administrator.
- 2.2 Continuation Coverage means the extended coverage under this Health FSA Plan, to the extent required under COBRA.
- 2.3 Dependent means (i) a dependent of the Participant who meets the definition in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (ii) any child of a Participant who meets the requirements in Code Section 152(f) who as of the end of the taxable year has not attained age 27.
- 2.4 Health FSA means the health flexible spending account to which salary reduction amounts are credited under Article 5.
- 2.5 Qualifying Event means (a) the death of a Participant; (b) termination (other than by reason of gross misconduct) of the Participant’s employment or reduction of hours of employment; (c) divorce or legal separation of a Participant from the Participant’s Spouse; or (d) a Dependent child of a Participant ceasing to be a Dependent.
- 2.6 Qualified Beneficiary means any person who is, as of the day before a Qualifying Event, (a) a Participant; (b) the Spouse of the Participant; or (c) a Dependent of the Participant. An Eligible Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours (if applicable) of the Eligible Employee’s employment. An individual

who fails to elect Continuation Coverage within the required election period shall not be a Qualified Beneficiary.

- 2.7 Qualifying Medical Expense means an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213 of the Code excluding long term care expenses (but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise, other than under this Health FSA Plan); provided, however, that Qualifying Medical Expense shall mean an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for a medicine or a drug only if such medicine or drug is a prescribed drug (without regard to whether such drug is available without a prescription) or is insulin. For this purpose, a prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. Premiums paid for other health plan coverage, including premiums paid for health coverage under a plan maintained by the employer of the Spouse or Dependent, shall not be reimbursable under this Health FSA Plan.

ARTICLE 3

PARTICIPATION

- 3.1 Eligibility. The eligibility requirements of this Health FSA Plan are set forth in Section 2.1 of the Section 125 Plan.
- 3.2 Participation During Non-FMLA Leave. If an Eligible Employee does not participate in this Health FSA Plan during non-FMLA Leave by continuing to pay for his or her cost of coverage with after-tax dollars during non-FMLA Leave or agreeing in advance to pay for his or her cost of coverage upon returning from non-FMLA Leave (in a manner prescribed by the Employer), he or she may not be reimbursed for expenses incurred during such leave.

The FMLA Leave provisions are set forth in Section 2.4 of the Section 125 Plan.

- 3.3 Termination of Participation. An Eligible Employee's participation in this Health FSA Plan shall terminate in accordance with Section 2.3 of the Section 125 Plan. However, in the event that an Eligible Employee ceases to be a Participant in the Plan for any reason, any election to receive reimbursements of Qualifying Medical Expenses, and any related Salary Reduction Agreement relating to Qualifying Medical Expenses shall terminate, subject to Continuation Coverage. The Participant (or his or her surviving Spouse or Dependents, if any, or his or her estate if the Participant is deceased) shall be entitled to reimbursement only for Qualifying Medical Expenses incurred before the date such termination occurs, and only if the Participant (or his or her surviving Spouse, Dependents or estate) applies for such reimbursement in accordance with Section 6.1 of this Health FSA Plan, on or before the April 15th after the end of the Plan Year in which the Participant's date of termination occurred. Notwithstanding the foregoing, if a

Participant experiences a Qualifying Event, he or she may be eligible to receive Continuation Coverage under the Health FSA Plan.

ARTICLE 4

ELECTION TO RECEIVE REIMBURSEMENT OF QUALIFYING MEDICAL EXPENSES

- 4.1 Election Procedure. An Eligible Employee may elect to receive payments or reimbursements of his or her Qualifying Medical Expenses under the Health FSA Plan by electing the Health FSA Plan as an Optional Benefit under the Section 125 Plan. An Eligible Employee may elect the Health FSA Plan as an Optional Benefit by following the procedures set forth in the Section 125 Plan (which are hereby incorporated by reference).
- 4.2 Irrevocability of Election. Elections under Section 4.1 of the Health FSA Plan are irrevocable during a Plan Year, except as permitted under the revocation rules set forth in Sections 3.7 through 3.9 of the Section 125 Plan (which are hereby incorporated by reference).
- 4.3 Termination of Election. If a Participant fails to pay his or her share of the cost of coverage under the Health FSA Plan that he or she elected, then his or her: (a) reimbursement election will be automatically revoked; (b) coverage under this Health FSA Plan will automatically terminate; and (c) he or she may be prohibited from making a new Health FSA election for the remainder of the Plan Year (except if, and to the extent, the Participant was on a FMLA Leave or other approved leave, or was affected by other circumstances, that permit suspension of payments, in which case he or she may be entitled to reinstatement in the Health FSA Plan as may be required under FMLA, other applicable law, or University of California policy).
- 4.4 Maximum Reimbursement. For the 2013 Plan Year, the maximum amount that a Participant may receive in reimbursements under this Health FSA Plan is \$2,500. In subsequent years, the limitations set forth in this Section 4.4 may be adjusted for cost of living increases as set forth in Section 125(i)(2) of the Code.

ARTICLE 5

HEALTH FLEXIBLE SPENDING ACCOUNTS

- 5.1 Establishment of Account. For bookkeeping purposes only, the Employer shall establish and maintain a Health FSA for each Plan Year with respect to each Participant who has elected participation in the Health FSA Plan as an Optional Benefit for that Plan Year.
- 5.2 Incurring Expenses. For purposes of the Health FSA Plan, a Participant incurs a Qualifying Medical Expense on the date service is provided rather than the date payment is requested, if later.

- 5.3 Crediting of Account. There shall be credited to a Participant's Health FSA, for each Plan Year, an amount equal to the Pre-Tax Contributions elected by the Participant under the Section 125 Plan, subject to the limits described in Section 4.4, above. The benefits provided hereunder will be paid solely from the general assets of the Employer. All amounts credited to a Participant's Health FSA shall be the property of the Employer until paid to the Participant under Article 6.

Nothing herein will be construed to require the Plan Sponsor, the Employer, or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Health FSA Plan from which any payment under the Health FSA Plan may be made.

- 5.4 Debiting of Account. A Participant's Health FSA for each Plan Year shall be debited from time to time in order to reimburse the Participant for Qualifying Medical Expenses incurred during the periods described in Section 6.2(b), below.
- 5.5 Forfeiture of Account. If any amount remains in the Participant's Health FSA for any Plan Year after all reimbursements have been paid in accordance with Article 6, such amounts will be automatically forfeited.

Such forfeited amounts will be used to defray the administrative costs of the flexible spending account plans.

ARTICLE 6

PAYMENT OF QUALIFYING MEDICAL EXPENSES

- 6.1 Claims for Reimbursement. To apply for reimbursement of Qualifying Medical Expenses, the Participant must submit an application in writing to the Claims Administrator, that includes:
- (a) The date and nature of the expense with respect to which reimbursement is requested;
 - (b) The name of the person, organization or entity to which the expense was or is to be paid;
 - (c) The name of the person for whom the expense was incurred and the relationship of such person to the Participant;
 - (d) A statement that the expense has not been reimbursed under any other insurance arrangement or any other health plan coverage;
 - (e) A written statement from an independent third party stating that the medical expense has been incurred, including the amount of the expense; and
 - (f) Such other information as the Claims Administrator may require.

Such application shall be accompanied by bills, invoices, receipts, canceled checks, or other kinds of proof as the Claims Administrator may require. Notwithstanding the foregoing, and subject to the same documentation requirements, Participants in the Health FSA Plan may also use a benefit card to pay for Qualifying Medical Expenses in accordance with procedures described in the Health FSA Summary Plan Description.

6.2 Reimbursement.

- (a) Payment. Subject to the documentation requirements described in Section 6.1, above, the Claims Administrator shall reimburse the Participant from the Participant's Health FSA for Qualifying Medical Expenses incurred by the Participant during the period of the Plan Year in which the individual was a Participant in the Health FSA Plan. Notwithstanding anything to the contrary in the Health FSA Plan, the Claims Administrator reserves the absolute right to determine what items will be eligible for reimbursement under the Health FSA Plan.
- (b) Timing. The amount credited to a Participant's Health FSA for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Expenses incurred during such Plan Year or during a "grace period" from January 1 through March 15 of the next Plan Year, and only if the Participant applies for reimbursement on or before the April 15th immediately following the close of the "grace period." Notwithstanding the foregoing, a Participant who has elected to participate in the University of California Health Savings Plan during a Plan Year immediately following a Plan Year in which he or she is a Participant in the Health FSA Plan, the Participant must apply for and receive all reimbursements for that Plan Year such that the Participant's Health FSA balance is zero (\$0) as of December 31st of that year.
- (c) Overpayment. In the event that a Participant's total reimbursement for a Plan Year exceeds the amount of the Participant's Compensation reduction for that year, the Participant shall be required to return such overpayment to the Employer.

6.3 Reimbursement After Termination of Employment. If a Participant terminates employment, the Participant (or his or her surviving Spouse and/or Dependents, if any, or estate if the Participant is deceased) shall be entitled to reimbursement only for Qualifying Medical Expenses incurred before the date such termination occurs, and only if the Participant (or his or her surviving Spouse and/or Dependents or estate) applies for such reimbursement in accordance with Sections 6.1 and 6.2 of the Health FSA Plan on or before the April 15th of the Plan Year next following the Plan Year in which the Participant's date of termination occurs. Notwithstanding the foregoing, if a Participant properly elects Continuation Coverage, he or she may be eligible to receive continued Health FSA Plan coverage after termination of employment with the Employer.

6.4 Reimbursement Amounts Available During Plan Year. The entire amount that a Participant has authorized to be allocated to his or her Health FSA for the Plan Year shall

be available at all times for reimbursement to the Participant (reduced by the amount of any prior reimbursements), regardless of the actual amount in his or her Health FSA on the date the Qualifying Medical Expense is incurred or submitted for reimbursement.

6.5 Reimbursement Amounts Available Following a Permitted Election Change Event. In the event of a permitted election change event (as described in Section 3.7 of the Plan), the amount in the Participant's Health FSA that shall be available for reimbursement of Qualifying Medical Expenses shall be equal to:

- (a) The initial amount that a Participant has authorized to be allocated to his or her Health FSA (expressed on a per pay period basis) multiplied by the number of pay periods for which it was effective; plus
- (b) Any subsequent amount that a Participant has authorized to be allocated to his or her Health FSA (expressed on a per pay period basis) based on the Participant's permitted election change event (as described in Section 3.7 of the Plan), multiplied by the number of pay periods for which such subsequent election or elections were effective; reduced by
- (c) The amount of any prior reimbursements.

In the event the amount available for reimbursement of Qualifying Medical Expenses changes during the Plan Year as a result of a permitted election change event (as described in Section 3.7 of the Plan), the amount available for reimbursement of Qualifying Medical Expenses at any time shall be the amount available at the time the expense is incurred.

6.6 Minimum Amount of Reimbursement. The Claims Administrator shall reimburse the Participant for Qualifying Medical Expenses incurred during the Plan Year from the Participant's Health FSA on a regular basis, subject to a minimum reimbursement amount of \$10 or, if less, an amount that will reduce the balance in the Health FSA to zero (\$0), and provided that the documentation and timing requirements set forth in this Article 6 are met.

6.7 Claims and Appeal Procedures. The claims and appeal procedures for the Health FSA Plan are set forth in the Health FSA Plan Summary Plan Description.

ARTICLE 7

CONTINUATION COVERAGE UNDER COBRA

This Health FSA Plan will comply fully with the requirements of COBRA as they apply to health flexible spending account plans.

ARTICLE 8

MISCELLANEOUS

- 8.1 Direct Payment to Third Party Provider. The Plan Administrator may pay any Qualifying Medical Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant.
- 8.2 Other Rules in Discretion of Plan Administrator. The Plan Administrator (or its delegate), in its sole discretion, may establish additional rules or procedures for the reimbursement of Qualifying Medical Expenses from a Participant's Health FSA.
- 8.3 Incorporation by Reference. Articles 2, 3, 5, 6, 7, and 8 of the Section 125 Plan (regarding eligibility, benefit elections, administration, amendment and termination, procedures for determining eligibility disputes, and miscellaneous) apply to the Health FSA Plan and are hereby incorporated by reference.

ARTICLE 9

HIPAA PRIVACY PROVISIONS

- 9.1 Introduction. The Health FSA Plan is a group health plan as defined by HIPAA. The University of California (the "Plan Sponsor") sponsors the Health FSA Plan. The Health Insurance Portability and Accountability Act of 1996, and the privacy regulations thereunder found at 45 C.F.R. Parts 160 and 164, as amended from time to time require the Health FSA Plan to restrict the Plan Sponsor's ability to Use and Disclose Protected Health Information that is received from the Health FSA Plan. One of the requirements is that the Plan Sponsor will amend the Health FSA Plan as set forth in 45 C.F.R. § 164.504(f)(2). In accordance with such requirements, the Health FSA Plan is hereby amended accordingly.
- 9.2 Definitions.
- (a) Business Associate. The term "Business Associate" has the meaning set forth in 45 C.F.R. § 160.103.
 - (b) Disclose or Disclosure. The term "Disclose" or "Disclosure" means the release or transfer of, provision of access to, or divulging in any other manner individually identifiable health information to persons outside the Plan Sponsor.
 - (c) HIPAA Privacy Rule. The term "HIPAA Privacy Rule" means the applicable requirements of the privacy rules of Health Insurance Portability and Accountability Act of 1996 and related regulations, Title 45 Parts 160 and 164 of the Code of Federal Regulations, as amended from time to time.
 - (d) Plan Administration Functions. The term "Plan Administration Functions" means administrative functions performed by the Plan Sponsor on behalf of the Health

FSA Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

- (e) Privacy Official. The term “Privacy Official” means the person who is responsible for the development and implementation of the HIPAA Privacy Rule policies and procedures of the Health FSA Plan.
- (f) Protected Health Information. The term “Protected Health Information” or “PHI” will have the meaning set forth in 45 C.F.R. § 160.103.
- (g) Use. The term “Use” means the sharing, employment, application, utilization, examination, or analysis of individually identifiable information by the Plan Sponsor or any Business Associate of the Health FSA Plan.

9.3 Permitted Uses and Disclosures of PHI by the Plan Sponsor.

- (a) General. The Health FSA Plan will Disclose PHI to the Plan Sponsor only to enable the Plan Sponsor to carry out Plan Administration Functions described in Section 9.3 (b) below, and such Disclosures will be consistent with the requirements of the HIPAA Privacy Rule. The Health FSA Plan will not Disclose PHI to the Plan Sponsor unless the Disclosures are explained in a Notice of Privacy Practices that is distributed to Covered Individuals.
- (b) Description of Uses of PHI by the Plan Sponsor. The Health FSA Plan may disclose PHI to specified employees or specified classes of employees of the Plan Sponsor solely for purposes of performing Plan Administration Functions, and only to the extent necessary for such purposes. Such Plan Administration Functions may include, but are not limited to, the design, administration, financial operations, review of denied claims on appeal, or legal defense of the Health FSA Plan. The Plan Sponsor will not Use or further Disclose the PHI other than as permitted or required in accordance with this stated purpose or as required by applicable law.

9.4 Agents. The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides PHI received from the Health FSA Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.

9.5 Employment Actions. The Plan Sponsor will not Use or Disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan that is sponsored by the Plan Sponsor except to the extent that such employee benefit plan is part of an Organized Health Care Arrangement (as defined in 45 C.F.R. § 164.501).

9.6 Reporting. The Plan Sponsor will report to the Privacy Official any Use or Disclosure of the information that is inconsistent with the purposes set forth in Section 9.3. above.

9.7 Access to the Information. The Plan Sponsor will make PHI available to Covered Individuals for inspection and copying in accordance with 45 C.F.R. § 164.524.

- 9.8 Amendment of PHI. The Plan Sponsor will make PHI available to Individuals (as defined in 45 C.F.R § 160.103) for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526.
- 9.9 Accounting of Disclosures of PHI. The Plan Sponsor will make available the PHI required for the Health FSA Plan to provide an accounting of Disclosures to Individuals in accordance with 45 C.F.R. § 164.528.
- 9.10 Information Available to the Secretary of Health and Human Services. The Plan Sponsor will make its internal practices, books, and records relating to the Use and Disclosure of PHI received from the Health FSA Plan available to the Secretary of Health and Human Services for purposes of determining the Health FSA Plan's compliance with the HIPAA Privacy Rule.
- 9.11 Return or Destroy PHI. If feasible, the Plan Sponsor will return or destroy all PHI received from the Health FSA Plan that it maintains in any form and retain no copies of such information when no longer needed for the purpose for which the Disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor will limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.
- 9.12 Adequate Separation.
- (a) General. The Plan Sponsor will ensure that there is adequate separation between the Health FSA Plan and the Plan Sponsor as required by the HIPAA Privacy Rule.
 - (b) Employees with Access to PHI. A description of the employees or classes of employees or other persons under the control of the Plan Sponsor that have been given access to PHI is included in the Plan Sponsor's HIPAA Employee Designation Document or similar document confirming such status.
 - (c) Restriction of Access and Use. The access to and Use by the persons described in Section 9.12 (b) above will be restricted to the Plan Administration Functions that the Plan Sponsor performs for the Health FSA Plan.
 - (d) Resolving Issues of Noncompliance. In the event there are any issues of noncompliance by the persons described in Section 9.12 (b) above, the Plan Sponsor will take all necessary and appropriate action that is consistent with its disciplinary policy.
- 9.13 Certification by the Plan Sponsor. The Health FSA Plan will not Disclose PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Health FSA Plan has been amended as required by the HIPAA Privacy Rule.

9.14 Miscellaneous.

- (a) Rights. This Article 9 shall not be construed to establish requirements or obligations beyond those required by the HIPAA Privacy Rule. Any portion of this Article 9 that appears to grant any additional rights not required by the HIPAA Privacy Rule shall not be binding upon the Plan Sponsor.
- (b) Amendment. The Plan Sponsor reserves the right to amend or terminate any and all provisions set forth in this Article 9 at any time to the extent permitted under the HIPAA Privacy Rule.
- (c) Document Retention. If a communication under this Article 9 is required by the HIPAA Privacy Rule to be in writing, the Plan Sponsor will maintain such writing, or electronic copy, as documentation. If an action, activity, or designation is required by the HIPAA Privacy Rule to be documented, the Plan Sponsor will maintain a written or electronic record of such action, activity or designation. The Plan Sponsor will retain the required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later.
- (d) Construction. The terms of this Article 9 shall be construed in accordance with the requirements of the HIPAA Privacy Rule and in accordance with any applicable guidance on the HIPAA Privacy Rule issued by the Department of Health and Human Services.

ARTICLE 10

HIPAA SECURITY

10.1 Introduction. The Health FSA Plan is subject to the requirements of the HIPAA Security Rule as set forth at 45 C.F.R. Parts 160 and 164, and specifically in accordance with 45 C.F.R. Section 164.314(b)(2). In accordance with such requirements, the Plan was amended to comply with such requirement.

10.2 Definitions.

- (a) Electronic Protected Health Information. The term “Electronic Protected Health Information” will have the meaning set forth in 45 C.F.R. Section 160.103.
- (b) HIPAA Security Rule. The term “HIPAA Security Rule” will mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164, subparts A and C.

10.3 HIPAA Security Rule Requirements. The Plan Sponsor will reasonably and appropriately safeguard Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan, other than Electronic Protected Health Information that is summary health information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45

C.F.R. Section 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508. In implementing such safeguards, the Plan Sponsor is required to do the following:

- (a) Safeguards. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Health FSA Plan.
- (b) Adequate Separation. The Plan Sponsor will ensure that the adequate separation between the Health FSA Plan and the Plan Sponsor as required by Section 164.504(f)(2)(iii) of the HIPAA Security Rule is supported by reasonable and appropriate security measures.
- (c) Agents. The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides Electronic Protected Health Information received from the Health FSA Plan agrees to implement reasonable and appropriate security measures to the Electronic Protected Health Information.
- (d) Reporting Obligation. The Plan Sponsor will report to the Health FSA Plan any security incident (as defined by 45 C.F.R. Section 164.304) of which it becomes aware.

10.4 Miscellaneous.

- (a) Rights. This Article 10 shall not be construed to establish requirements or obligations beyond those required by the HIPAA Security Rule. Any portion of this Article 10 that appears to grant any additional rights not required by the HIPAA Security Rule shall not be binding upon the Plan Sponsor.
- (b) Amendment. The Plan Sponsor reserves the right to amend or terminate any and all provisions set forth in this Article 10. At any time to the extent permitted under the HIPAA Security Rule.
- (c) Construction. The terms of this Article 10 shall be construed in accordance with the requirements of the HIPAA Security Rule and in accordance with any applicable guidance on the HIPAA Security Rule issued by the Department of Health and Human Services.

APPENDIX C

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

ARTICLE 1

PURPOSE OF THE PLAN

- 1.1 Introduction. The Dependent Care Flexible Spending Account Plan (the “DepCare FSA Plan”) is intended to qualify as a “dependent care assistance program” within the meaning of Section 129 of the Code. The purpose of the DepCare FSA Plan is to enable Participants to pay for qualifying Dependent Care Expenses on a pre-tax basis. To participate in the DepCare FSA Plan, an Eligible Employee must elect to contribute a minimum of \$180 per Plan Year.

ARTICLE 2

DEFINITIONS

Capitalized terms shall have the same meaning given to them in the Section 125 Plan. Whenever used in this Appendix B, the following terms have the following meanings unless a different meaning is clearly required by the context:

- 2.1 Claims Administrator means the Plan Administrator or such other entity as designated in writing by the Employer and/or Plan Administrator.
- 2.2 DepCare FSA means the dependent care flexible spending account to which salary reduction amounts are credited under Article 5.
- 2.3 Dependent means a qualifying individual (as defined in Code Section 21(b)(1)). This includes the following:
- (a) A Participant’s child, brother, sister, stepbrother, stepsister (or a descendant of any of these) under the age of 13 who has the same principal place of abode as the Participant for more than one-half of the taxable year and who has not provided over one-half of his or her own support for the calendar year in which the Participant’s taxable year begins; and
 - (b) Any of the following who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the taxable year:
 - (1) The Participant’s child, brother, sister, stepbrother, stepsister (or a descendant of any of these) who is under the age of 19, a full-time student under the age of 24, or who is permanently and totally disabled (as defined in Code Section 22(e)(3)), and who has not provided over one-half of his

or her own support for the calendar year in which the Participant's taxable year begins; or

- (2) The Participant's child (or a descendent of the child), brother, sister, stepbrother, stepsister, parent, grandparent, stepparent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, with respect to whom the Participant provides over one-half his or her support for the calendar year in which the Participant's taxable year begins, and who is not the qualifying child (as defined in Code Section 152(c)) of any person; or
 - (3) Any person (other than the Participant's Spouse) with respect to whom the Participant provides over one-half his or her support for the calendar year in which the Participant's taxable year begins, and who is not the qualifying child (as defined in Code Section 152(c)) of any person, and, for the taxable year of the Participant, has the same principal place of abode as the Participant and is a member of the Participant's household; and
- (c) The Participant's Spouse who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the taxable year.

For purposes of this Section 2.3, the term "child" includes a biological child, stepchild, eligible foster child, legally adopted child, or child placed with the Participant for legal adoption by the Participant.

2.4 Dependent Care Expense means an expense incurred by a Participant which is:

- (a) Incurred for the care of a Dependent of the Participant or for related household services;
- (b) Paid or payable to a Dependent Care Reimbursement Service Provider; and
- (c) Incurred to enable the Participant and the Participant's Spouse to be gainfully employed for any period for which there are one or more Dependents with respect to the Eligible Employee.

Dependent Care Expenses shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 2.3, above or the Dependent regularly spends at least eight hours each day in the Participant's household. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expense relate are provided, rather than at the time payment for such services is made.

2.5 Dependent Care Reimbursement Service Provider means a person who provides care or other services, but does not include:

- (a) An individual with respect to whom a deduction under Section 151 of the Code is allowable to the Participant or his or her Spouse;
- (b) A child (within the meaning of Section 152 of the Code) of the Participant under the age of 19; or
- (c) A dependent care center which:
 - (1) Provides such care for more than six individuals (other than the individuals who reside at the facility); and
 - (2) Receives a fee, payment or grant for the care provided for any of the individuals,

unless such dependent care center complies with all applicable laws and regulations of a state or unit of local government.

2.6 Spouse means the individual to whom a Participant is legally married.

ARTICLE 3

PARTICIPATION

3.1 Eligibility. The eligibility requirements of this DepCare FSA Plan are set forth in Section 2.1 of the Section 125 Plan.

3.2 Termination of Participation. An Employee's participation in this DepCare FSA Plan shall terminate in accordance with Section 2.3 of the Section 125 Plan.

ARTICLE 4

ELECTION TO RECEIVE REIMBURSEMENT OF DEPENDENT CARE EXPENSES

4.1 Election Procedure. A Participant may elect to receive payments or reimbursements of his or her Dependent Care Expenses under the DepCare FSA Plan by electing the DepCare FSA Plan as an Optional Benefit under the Section 125 Plan. A Participant may elect the DepCare FSA Plan as an Optional Benefit by following the procedures set forth in the Section 125 Plan (which are hereby incorporated by reference).

4.2 Revocability of Election. Elections under Section 4.1 of this DepCare FSA Plan are irrevocable during a Plan Year, except as permitted under the revocation rules set forth in Section 3.7 of the Section 125 Plan (which are hereby incorporated by reference).

4.3 Maximum Dependent Care Reimbursement Assistance. The maximum amount which the Participant may receive in any Plan Year in the form of reimbursements or payments for Dependent Care Expenses under the DepCare FSA Plan shall be the least of:

- (a) The Participant's earned income for the Plan Year (after reductions in Compensation under Section 125 of the Code, including the reduction related to dependent care reimbursement assistance);
- (b) The actual or deemed earned income of the Participant's Spouse, if applicable, for the Plan Year; or
- (c) \$5,000, reduced by any amounts contributed by the Participant's Spouse to a plan that pays or reimburses Dependent Care Expenses (\$2,500 in the case of a married individual filing a separate tax return).

In the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such Spouse shall be deemed to have earned income of not less than \$250 per month if the Participant has one Dependent and \$500 per month if the Participant has two or more Dependents.

ARTICLE 5

DEPENDENT CARE SPENDING ACCOUNTS

5.1 Establishment of Account. For bookkeeping purposes only, the Employer shall establish and maintain a DepCare FSA for each Plan Year with respect to each Participant who has elected participation in the DepCare FSA Plan as an Optional Benefit for that Plan Year.

5.2 Crediting of Account. There shall be credited to a Participant's DepCare FSA, for each Plan Year, an amount equal to the amount elected by the Participant in accordance with such Participant's election under the Section 125 Plan. The benefits provided hereunder will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Plan Sponsor, the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the DepCare FSA Plan from which any payment under the DepCare FSA Plan may be made.

All amounts credited to each such DepCare FSA shall be the property of the Employer until paid to a Participant under Article 6 of the DepCare FSA Plan.

5.3 Debiting of Account. A Participant's DepCare FSA for each Plan Year shall be debited from time to time to reimburse the Participant for Dependent Care Expenses incurred during the periods described in Section 6.2(b), below.

5.4 Forfeiture of Account. If any amount remains in the Participant's DepCare FSA for any Plan Year after all reimbursements have been paid in accordance with Article 6, such amounts will be automatically forfeited.

Such forfeited amounts will be used to defray the administrative costs of the flexible spending account plans.

ARTICLE 6

PAYMENT OF DEPENDENT CARE EXPENSES

- 6.1 Claims for Reimbursement. A Participant who has elected to participate in the DepCare FSA Plan for the Plan Year may apply to the Claims Administrator for reimbursement of Dependent Care Expenses incurred by the Participant during the period of the Plan Year in which the Eligible Employee was a Participant in the DepCare FSA Plan by submitting an application in writing to the Claims Administrator, in such form as the Claims Administrator may prescribe, setting forth:
- (a) The date and nature of the expense with respect to which reimbursement is requested;
 - (b) The name of the person, organization or entity to which the expense was or is to be paid;
 - (c) The name of the person for whom the expense was incurred and the relationship of such person to the Participant;
 - (d) A statement that the expense has not been reimbursed under any other insurance arrangement or any other dependent care reimbursement assistance plan coverage;
 - (e) A written statement from an independent third party stating that the dependent care reimbursement expense has been incurred, including the amount of the expense; and
 - (f) Such other information as the Claims Administrator may from time to time require.

The Claims Administrator may require such application to be accompanied by bills, invoices, receipts, canceled checks, or other proof (as may be required by the Plan Administrator).

6.2 Reimbursement.

- (a) Payment. The Claims Administrator shall reimburse the Participant from the Participant's DepCare FSA for Dependent Care Expenses incurred during the period of the Plan Year in which the individual was a Participant in the DepCare FSA Plan, subject to all applicable requirements and/or limitations set forth in the Section 125 Plan and/or this Appendix C; provided that reimbursement will not be made for expenses incurred during any period of absence from gainful employment that is not a "short, temporary absence" within the meaning of Treasury Regulations Section 1.21-1(c)(2)(ii). Notwithstanding anything to the contrary in the DepCare FSA Plan, the Claims Administrator reserves the absolute

right to determine what items will be eligible for reimbursement under the Health FSA Plan.

- (b) Timing. The amount credited to a Participant's DepCare FSA for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year or during a "grace period" from January 1 through March 15 of the next Plan Year, and only if the Participant applies for reimbursement on or before the April 15th immediately following the close of the "grace period."
- (c) Overpayment. In the event that a Participant's total reimbursement for a Plan Year exceeds the amount of the Participant's Compensation reduction for that year, the Participant shall be required to return such overpayment to the Employer.

6.3 Reimbursement After Termination of Employment. If a Participant terminates employment, the Participant (or his or her surviving Spouse, if any, or his or her estate if the Participant is deceased) shall be entitled to reimbursement only for Dependent Care Expenses incurred before the date such termination occurs, and only if the Participant (or his or her surviving Spouse or estate) applies for such reimbursement in accordance with Sections 6.1 and 6.2 on or before the April 15th of the Plan Year next following the Plan Year in which the Participant's date of termination occurs. Continuation Coverage through the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") does not apply to the DepCare FSA Plan.

6.4 Reimbursement Amounts Available Following a Permitted Election Change Event. In the event of a permitted election change event (as described in Section 3.7 of the Plan and subject to the rules set forth in the Section 125 Plan), the amount in the Participant's DepCare FSA that shall be available for reimbursement of Dependent Care Expenses shall be equal to:

- (a) The initial amount that a Participant has authorized to be allocated to his or her DepCare FSA (expressed on a per pay period basis) multiplied by the number of pay periods for which it was effective; plus
- (b) Any subsequent amount that a Participant has authorized to be allocated to his or her DepCare FSA (expressed on a per pay period basis) based on the Participant's permitted election change event (as described in Section 3.7 of the Plan), multiplied by the number of pay periods for which such subsequent election or elections were effective; reduced by the amount of any prior reimbursements.

In the event the amount available for reimbursement of Dependent Care Expenses changes during the Plan Year as a result of a permitted election change event (as described in Section 3.7 of the Plan), the amount available for reimbursement of Dependent Care Expenses at any time shall be the amount available at the time the reimbursement claim is received by the Claims Administrator.

- 6.5 Minimum Amount of Reimbursement. The Plan Administrator shall reimburse the Participant for Dependent Care Expenses incurred during the Plan Year from the Participant's DepCare FSA on a regular basis, subject to a minimum reimbursement amount of \$10, or, if less, an amount that will reduce the balance in the DepCare FSA to zero (\$0), and provided that the documentation and timing requirements set forth in this Article 6 are met.
- 6.6 Reimbursement When Insufficient Funds in DCSA. Reimbursement of Dependent Care Expenses incurred during a Plan Year shall not at any time exceed the balance of the Participant's DCSA at the time the reimbursement claim is received by the Claims Administrator. The amount of any Dependent Care Expenses not reimbursed or paid because of the unavailability of amounts in a DCSA shall be paid if and when there are sufficient funds in the DepCare FSA. Dependent Care Expenses in no event will be carried over to another Plan Year.
- 6.7 Maximum Amount of Reimbursement. The total amount of reimbursements or payments under this Article 6 of expenses incurred during a Plan Year shall not exceed the amount of dependent care assistance the Participant has elected to receive during the Plan Year, subject to statutory limits imposed under the Code.
- 6.8 Claims and Appeal Procedures. The claims and appeal procedures for the DepCare FSA Plan are set forth in the DepCare FSA Plan Summary Plan Description.

ARTICLE 7

REPORTING AND DISCLOSURE

- 7.1 Reports to Participants. The Plan Administrator shall report the amount of each Participant's Dependent Care Expenses reimbursed during the prior calendar year on each Participant's Form W-2.

ARTICLE 8

ADMINISTRATION

- 8.1 Incorporation by Reference. Articles 2, 3, 5, 6, and 8 of the Section 125 Plan (regarding eligibility, benefit elections, administration, amendment and termination, and miscellaneous) apply to the Plan and are hereby incorporated by reference.

APPENDIX D

HEALTH SAVINGS ACCOUNT

ARTICLE 1

PURPOSE OF THE HEALTH SAVINGS ACCOUNT

- 1.1 The Health Savings Account is intended to permit Participants to contribute pre-tax dollars or after-tax dollars to a Health Savings Account. This Appendix D does not establish the Health Savings Account but describes the procedure by which Participants in the Section 125 Plan can make Pre-Tax Contributions to a Health Savings Account established by or on behalf of the Participant. Participants with an established Health Savings Account can also make direct payments to such account on an after-tax basis in accordance with procedures established by the Health Savings Account Custodian.

ARTICLE 2

DEFINITIONS

Capitalized terms shall have the same meaning given to them in the Section 125 Plan. Whenever used in this Appendix D, the following terms have the following meanings unless a different meaning is clearly required by the context:

- 2.1 Custodian means the Health Savings Account “custodian” specified by the Employer.
- 2.2 Health Savings Account means a “health savings account” as defined in section 223(d) of the Code established with the Custodian.
- 2.3 High Deductible Health Plan means a “high deductible health plan” as defined in section 223(c)(2) of the Code.
- 2.4 Qualified Medical Expenses means “qualified medical expenses” as defined in section 223(d)(2) of the Code.

ARTICLE 3

PARTICIPATION

- 3.1 Eligibility. The general eligibility provisions are set forth in Section 2.1 of the Section 125 Plan.
- 3.2 Termination of Participation. An employee’s participation shall terminate in accordance with Section 2.3 of the Section 125 Plan.

ARTICLE 4

ELECTIONS

- 4.1 In General. A Participant is eligible to make Pre-Tax Contributions under this Appendix D if he or she:
- (a) is a participant in the Employer-sponsored High Deductible Health Plan;
 - (b) is not a participant in any health plan which is not a High Deductible Health Plan; provided, however, that certain coverage is disregarded in accordance with Code Section 223(c)(1)(B);
 - (c) is not enrolled in Medicare;
 - (d) cannot be claimed as a dependent on another taxpayer's tax return;
 - (e) is not a Participant in the Health FSA Plan; and
 - (f) has established a Health Savings Account in accordance with the rules established by the Employer with the Health Savings Account Custodian.
- 4.2 Elections. A Participant must make an affirmative deferral election during the period established by the Plan Administrator. Each eligible Participant who elects to make Pre-Tax Contributions to his or her Health Savings Account may increase or decrease his or her contribution level, or may suspend or restart his or her contributions, during the Plan Year in accordance with rules established by the Plan Administrator, which shall, at a minimum, allow changes to be made prospectively on a monthly basis. All Pre-Tax Contributions made under the Health Savings Account shall be made to the account established with the Custodian, as defined in Section 2.1, above.
- 4.3 Participant Contributions.
- (a) The maximum amount that a Participant may elect to contribute to his or her Health Savings Account is (i) \$3,300 in 2014 in the case of an eligible Participant who has self-only coverage under the High Deductible Health Plan as of the first day of the month, or (ii) \$6,550 in 2014 in the case of an eligible Participant who has family coverage under the High Deductible Health Plan as of the first day of the month, less the maximum amount, if any, that the Employer has elected to contribute to the Participant's Health Savings Account for the applicable Plan Year.
 - (b) The limitations set forth in Section 4.3(a), above, shall be adjusted for cost of living increases as set forth in Code Section 223(g).
- 4.4 Employer Contributions. The Employer may, but is not required to, make a contribution to a Participant's Health Savings Account on account of the Participant. Any such contribution shall result in a reduction in the amount that the Participant may contribute

to the Health Savings Account, as described in Section 4.3(a), above. If a Participant does not establish a Health Savings Account in accordance with rules established by the Employer and the Custodian, the Employer will not make a contribution to the Participant's Health Savings Account. However, if a Health Savings Account is established, but the Participant does not make Pre-Tax Contributions, the Employer will make a contribution to the account.

- 4.5 Catch-Up Contributions. A Participant who has attained age 55 before the end of the Plan Year and who is otherwise eligible to contribute, as described in Section 4.3, above, may make an additional Pre-Tax Contribution in accordance with section 223(b)(3) of the Code.
- 4.6 First Year Eligibility. In the case of a Participant who becomes an eligible Participant for the first time during the Plan Year and who is an eligible Participant in the last month of the Plan Year, such Participant may elect to make the maximum contribution permitted under Section 4.3; provided, however, that such Participant must remain an eligible Participant through the end of the subsequent Plan Year.

ARTICLE 5

ADMINISTRATION

- 5.1 Incorporation by Reference. Article 2, 5, 6 and 8 of the Section 125 Plan apply to this Appendix D and are hereby incorporated by reference.