UNIVERSITY OF VERMONT

FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

Effective: January 1, 2007
Revised: January 1, 2021

Administered by:

ebpa
EMPLOYEE BENEFITS

UNIVERSITY OF VERMONT
FLEXIBLE BENEFITS PLAN

INTRODUCTION

This is a summary of the University of Vermont Flexible Benefits Plan (the "Plan").

This booklet is provided to help you understand how the Plan works. It highlights what types of expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan.

University of Vermont is sponsoring this self-funded plan for University of Vermont which provides flexible benefits for all covered employees.

Each covered employee is entitled to the benefits outlined in this Plan Document. To obtain benefits from the Plan, the covered person must ultimately submit a claim to the Contract Administrator, Employee Benefit Plan Administration, LLC dba Employee Benefit Plan Administration, for processing. This claim submission is required for reimbursement to the employee by the University of Vermont Flexible Benefits Plan.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, the Contract Administrator (the third-party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan document, which is also the Summary Plan Description.

A clerical error will neither invalidate the employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

In accordance with the Plan's status as a self-funded plan, the Contract Administrator shall administer the Plan to comply with any introduced Code of Federal Regulations (CFR) or related amendments, from the executive departments and agencies of the federal government, that pertain to a participant's access to the benefits described herein, including covered and/or excluded expenses, filing procedures, and review procedures.

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GENERAL INFORMATION

Name of the Plan: University of Vermont Flexible Benefits Plan

Plan Sponsor: University of Vermont
85 South Prospect Street
228 Waterman Building
Burlington, VT 05405
(802) 656-3131

Plan Number: 502

Group Number: 10683

Plans Covered: Health Care Reimbursement Account
Dependent Care Reimbursement Account

Federal Identification Number: 03-0179440

Plan Effective Date: January 1, 2007

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Plan Revision Date: January 1, 2021- This document replaces the previous Flexible Benefit Plan in its entirety. All claims incurred prior to January 1, 2021 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator:
Employee Benefit Plan Administration, LLC dba Employee Benefit Plan Administration (EBPA)
P.O. Box 1140
Exeter, NH 03833-1140
(603) 778-7106 or (888) 678-3457

Plan Administrator: University of Vermont

Agent for Service of Legal Process: University of Vermont

Eligibility Requirements: All full-time employees engaged in regular active employment performing at least 18.75 hours of service per week.

Eligibility Date: First day of employment.

Termination Date: See "Termination of Benefits" section.

PURPOSE OF THE PLAN

The University of Vermont Flexible Benefits Plan is a benefit program that allows Eligible Employees to use benefit dollars on a Salary Reduction (i.e., pre-tax) basis for:

1. payment of eligible unreimbursed medical, dental and/or vision expenses; and

2. payment of eligible dependent care expenses.

An Eligible Employee may participate in any or all of the above benefits using pre-tax dollars deducted from their paycheck on a regularly scheduled basis.

This Plan is intended to qualify as a "cafeteria plan" under Code § 125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105(h), and the Medical Care Expenses reimbursed under that component are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b).

The DCAP Component of this Plan is intended to qualify as a "dependent care assistance plan" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of COBRA.

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the "Definitions" section contained herein.

ELIGIBILITY & ENROLLMENT

Eligibility: Only Employees who satisfy the eligibility requirements set forth in the "General Information" section contained herein are eligible for coverage under this Plan.

Plan Enrollment: Employees who are eligible as of the Plan Effective Date may enroll immediately. An Eligible Employee will be enrolled when a Plan Enrollment Form is completed, signed, and delivered to the Plan Administrator. An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that a Plan Enrollment Form is submitted to the Plan Administrator before the first day of the month in which participation will commence. Any Eligible Employee who fails to return a completed election form by the due date for their initial election will be deemed to have not elected any benefits under this Plan.

Subsequent Enrollment: During the Open Enrollment Period prior to each Plan Year, each Eligible Employee will be given the opportunity to select or modify benefit elections. An Eligible Employee who initially elected not to participate may choose new elections for the subsequent Plan Year.

The Plan Enrollment Form shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Plan Enrollment Form must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year. If an Eligible Employee fails to return the Plan Enrollment Form during the Open Enrollment Period, then the Employee may not elect to participate in this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in the "Mid Year Change in Employee Elections" section.

Irrevocability of Elections: Unless an exception applies (as described in the "Mid Year Change in Employee Elections" section), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

There will be a special open enrollment for flexible benefits account changes from April 5, 2021 through April 23, 2021 for an effective date of May 1, 2021. Employees may submit a plan enrollment form to:

- Enroll in Health FSA or Dependent Care for plan year 2021;
- Increase or decrease FSA elections for health or dependent care for the remaining portion of the calendar year 2021. Decreases must not exceed what has been collected during this current calendar year.

HEALTH FSA COMPONENT

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA Benefits); and (b) to pay the premium for such Health FSA Benefits on a Salary Reduction basis. Unless an exception applies (as described in the "Mid Year Change in Employee Elections" section), such election is irrevocable for the duration of the Period of Coverage to which it relates.

The annual premium for a Participant's Health FSA Benefits is the maximum contribution allowed for the account at the beginning of the Plan Year as set by the Employer. Each Participant may contribute an amount each Plan Year up to that maximum.

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

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

(b) *Medical Care Expenses.* "Medical Care Expenses" means expenses incurred by a Participant or their Spouse or Dependents for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through a group health plan, other insurance, or any other accident or health plan. The expenses must be to alleviate or prevent a physical defect or illness. Expenses solely for cosmetic reasons or expenses that are merely beneficial to one's general health (for example, vacations) are not reimbursable expenses under the Health FSA Component. In addition, Participants' premium payments for other health coverage are not reimbursable under the Health FSA Component. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the group health plan imposes co-payment or deductible limitations), the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this "Health FSA Component" section.

The following is a partial list of Medical Care Expenses. For detailed explanations of these expenses, or for information regarding other types of expenses, contact the Contract Administrator.

Ambulance Services
Acupuncture
Birth Control Methods by Prescription
Chiropractic Care
Deductible Expense
Dental Care
Durable Medical Equipment
Laboratory Fees
Legal Abortions
Medical Services
Mental Health Treatment
Nursing Home
Nursing Services
Orthodontics

Eye Exams and Prescribed Glasses/Contact Lenses
Hearing Exams and Hearing Aids
Hospital Services
Over-the Counter Drugs & Medicines when prescribed (other than insulin)
Prescription Drugs
Substance Abuse Treatment
Surgical Expense for legal procedures

A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Contract Administrator in such form as the Contract Administrator may prescribe, by no later than March 31 following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

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

For reimbursement claims that are denied, see the "Claim Review Procedures" section.

Named Fiduciary. University of Vermont is the named fiduciary for the Health FSA Component.

Laws Applicable to Group Health Plans. Health FSA Benefits shall be provided in compliance with COBRA, HIPAA, etc.

Coordination of Benefits. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA Benefits shall not be considered a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

CARRYOVER AMOUNTS

A participant will be able to carryover up to $550 of unused amounts remaining in their Health FSA as of the end of the Plan Year. The carryover of up to $550 may be used to pay or reimburse qualifying medical expenses under the Health FSA incurred during the entire Plan Year to which it is carried over. For this purpose, the unused amount remaining as of the end of the Plan Year is the amount unused after eligible medical expenses have been reimbursed at the end of the claims runout period for the Plan Year. The carryover of up to $550 does not count against or otherwise affect the maximum contribution amount.

The Plan will treat reimbursements of all claims for expenses that are incurred in the current Plan Year as reimbursed first from unused amounts credited for the current Plan Year, and, only after exhausting these current Plan Year amounts, as then reimbursed from unused amounts carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current year expense (i) reduce the amounts available to pay prior Plan Year expenses during the run-out period, (ii) must be counted against the permitted $550 carryover, and (iii) cannot exceed the $550 permitted carryover amount.

The FSA carryover provision does not apply to dependent care.

Unused carryover amounts remaining at termination of employment are forfeited unless the participant elects COBRA under the Health FSA. Participants will be permitted to use any carryover amounts remaining in the Health FSA at the end of the 2021 plan year to pay or reimburse medical expenses incurred through December 31, 2022.

Debit Card Use. In addition, a Participant in the Health FSA Component may use the Flex debit card. As explained more fully in the employee enrollment agreement, this card permits Participants to pay for Medical Care Expenses at qualified merchants or health care providers with the Flex debit card instead of paying out-of-pocket money for such expenses and submitting an application to be reimbursed for such amounts as described above. Each Participant in the Health FSA Component will be issued a Flex debit card and will certify upon enrollment in the Health FSA Component *and each Plan Year thereafter* that the card will be only used for Medical Care Expenses. Participant-cardholders will also certify that any expense paid with the card has not been reimbursed and that the Participant will not seek reimbursement under any other plan covering health benefits. Participant-cardholders must acquire and retain sufficient documentation for any expense paid with the Flex debit card, including invoices and receipts where appropriate. The Participant's use of the Flex debit card is limited to the maximum dollar amount of coverage in the Health FSA Component. Upon the Participant's termination of employment, the Flex debit card will be automatically cancelled.

The following requirements relate to the use of the Flex debit card:

- If the dollar amount of the transaction at a health care provider equals the dollar amount of the copayment for that service under the major medical plan of the Participant, the charge is fully substantiated without the need for submission of a receipt or further review. For example, Employee A is enrolled in a major medical plan with a $15 physician's office visit copayment. When Employee A uses the card to satisfy the copayment requirement, the system matches the amount of the transaction, $15, with the copayment under Employee A's coverage and the fact that the transaction is at a physician's office.

- There will be automatic reimbursement, without further review, of recurring expenses that match expenses previously approved as to amount, provider, and time period (e.g., for a participant who refills a prescription drug on a regular basis at the same provider for the same amount).

- If the Employer's accident or health plan has copayments in specific dollar amounts, and the dollar amount of the transaction at a health care provider (as identified by it's merchant category code) equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service (i.e., pharmacy benefit copayment, copayment for a physician's office visit, etc.) then the charge is fully substantiated without the need for submission of a receipt or further review.

- If the merchant, service provider, or other independent third-party (e.g., Pharmacy Benefit Manager), at the time and point of sale, provides information to verify to University of Vermont (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review (i.e., "real-time substantiation"). For example, Employee A fills a prescription at a pharmacy. The Pharmacy Benefit Manager under Employee A's major medical coverage provides information that $37.85 of the cost of the prescription is a medical expense that is not covered by the major medical coverage. Because the information about the medical expense, $37.85, matches the amount of the transaction, the transaction is substantiated. The additional third-party information regarding the type of care, date of service, and amount provides substantiation of the expense without the need for further review.

- All charges to the Flex card, other than copayments, recurring expenses, and real-time substantiation as described above, are treated as conditional pending confirmation of the charge. Additional third-party information, such as merchant or service provider receipts, describing (1) the service or product, (2) the date of the service or sale and, (3) the amount, must be submitted for review and substantiation.

- If a claim that has been reimbursed is subsequently identified as not qualifying for reimbursement, the following procedures will apply.

    - Step 1: Upon identification by the Contract Administrator of an improper payment, the Participant will be notified by the Contract Administrator of the improper payment. The Participant, in accordance with the instructions provided by the Contract Administrator, must pay back to the Plan an amount equal to the improper payment.

- Step 2: If payment is not made by the Participant in accordance with the instructions provided by the Contract Administrator, the amount of the improper payment will be withheld from the Participant's wages or other compensation to the extent consistent with applicable law.

- Step 3: If the improper payment still remains outstanding, the Contract Administrator will use a claims substitution or offset approach to resolve improper claims. For example, if Employee A has received an improper reimbursement of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement is made until the improper payment is fully recouped.

- In addition to the above, while the improper payment remains outstanding, the Contract Administrator may take other actions to ensure that further violations of the terms of the Flex card do not occur, including denial of access to the card until the indebtedness is repaid by the Participant.

- If these correction efforts prove unsuccessful, or are otherwise unavailable, the Participant remains indebted to University of Vermont for the amount of the improper payment. In that event and consistent with its business practices, the University of Vermont will treat the payment as it would any other business indebtedness.

DCAP COMPONENT

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses, and to pay the premium for such benefits on a Salary Reduction basis (DCAP Benefits). Unless an exception applies (as described in the "Mid Year Change in Employee Elections" section), such election is irrevocable for the duration of the Period of Coverage to which it relates.

The annual premium for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant up to the maximum annual benefit amount allowed for the account at the beginning of the Plan Year.

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

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

(b) *Dependent Care Expenses*. "Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code § 21 (b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this "DCAP Component" section.

(c) *Qualifying Individual.* "Qualifying Individual" means:

- a Participant's Dependent who is under the age of thirteen (13). For the 2020 plan year, the participant is allowed reimbursement of unused dependent care expenses for children enrolled in the plan until they attain the age of fourteen (14). For the 2021 plan year, the participant is allowed reimbursement of unused dependent care expenses for children until they attain the age of fourteen (14), but only for unused dependent care expenses carried over from 2020 into 2021;
- a Participant's Dependent who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- a Participant's Spouse who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year.

(d) *Qualifying Dependent Care Services*. "Qualifying Dependent Care Services'" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and their Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's Dependent who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.

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

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or their Spouse;
- a Participant's Spouse; or
- a Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred.

Dependent Care Expenses include:

- Only those expenses related to a child's protection and well-being;

- The full amount paid to a nursery school is considered a Dependent Care Expense, even if the nursery school provides educational services. However, educational expenses for a child in first grade or above are not Dependent Care Expenses;

- Summer day camp expenses qualify as Dependent Care Expenses, but overnight camp expenses are not Dependent Care Expenses. Generally, evening babysitting would not qualify as Dependent Care Expenses unless a single parent or both married parents work in the evening;

- Expenses paid for household services are Dependent Care Expenses if they pertain to services provided in the Participant's home that are "ordinary and usual", "necessary to the maintenance of the household" and are attributable at least in part to the care of the Qualifying Individual;

- Payment of payroll taxes by a Participant in connection with compensation paid to a service provider is a Dependent Care Expense.

Dependent Care Expenses do not include the cost of transportation, clothing, entertainment, or food unless such items are incidental and cannot be separated from the cost of the care provided.

No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $200 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $400 per month); or
- Either $5,000 or $2,500 for the calendar year, as applicable:
  (1) $5,000 for the calendar year if one of the following applies:
  (A) the Participant is married and files a joint return;
  (B) the Participant is married, but (1) furnishes more than one-half the cost of maintaining the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP; (2) the Participant's Spouse maintains a separate residence for the last six months of the calendar year; and (3) the Participant files a separate tax return; or
  (C) the Participant is single or is the head of the household for tax purposes; or
  (2) $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

For the 2021 plan year only, the dependent care statutory limit for a participant will be:

- Either $10,500 or $5,520 for the calendar year, as applicable:
  (1) $10,500 for the calendar year if one of the following applies:
  (A) the Participant is married and files a joint return;
  (B) the Participant is married, but (1) furnishes more than one-half the cost of maintaining the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP; (2) the Participant's Spouse maintains a separate residence for the last six months of the calendar year; and (3) the Participant files a separate tax return; or
  (C) the Participant is single or is the head of the household for tax purposes; or
  (2) $5,520 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

There will be a special open enrollment for flexible benefits account changes from April 5, 2021 through April 23, 2021 for an effective date of May 1, 2021. Employees may submit a plan enrollment form to:

- Enroll in Health FSA or Dependent Care for plan year 2021;
- Increase or decrease FSA elections for health or dependent care for the remaining portion of the calendar year 2021. Decreases must not exceed what has been collected during this current calendar year.

A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Contract Administrator in such form as the Contract Administrator may prescribe, by no later than March 31 following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person or persons on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and
- a statement that such Expenses have not otherwise been paid and are not expected to be paid through any other source.

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

For reimbursement claims that are denied, see the "Claims Review Procedures" section.

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

Debit Card Use. A Participant in the DCAP Component may use the Flex debit card. Each Participant in the DCAP Component will be issued a Flex debit card and will certify upon enrollment in the DCAP Component *and each Plan Year thereafter* that the card will be only used for Dependent Care Expenses. Participant-cardholders will also certify that any expense paid with the card has not been reimbursed and that the Participant will not seek reimbursement under any other plan covering dependent care benefits. Participant-cardholders must acquire and retain sufficient documentation for any expense paid with the Flex debit card, including invoices and receipts where appropriate. The Participant's use of the Flex debit card is limited to the maximum dollar amount of coverage in the DCAP Component. Upon the Participant's termination of employment, the Flex debit card will be automatically cancelled.

The following requirements relate to the use of the Flex debit card for dependent care expenses:

- Cards may not be used to pay for dependent care expenses before the expenses are incurred. For this purpose, expenses are incurred when the dependent care services are provided, not when the DCAP participant pays or is billed for them. For example, if an employee pays for dependent care on a monthly basis, the charge for each month is not considered to be incurred until the last day of that month, when all of the services giving rise to the charge have been provided. IRS guidance specifically provides that "if a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a payment card program."

- All charges to the Flex card, other than recurring expenses, are treated as conditional pending confirmation of the charge. Additional third-party information, such as service provider receipts, describing (1) person or persons on whose behalf Dependent Care Expenses have been incurred , (2) the nature and date of the Expenses so incurred, (3) the amount of the requested reimbursement; (4) the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and (5) a statement that such Expenses have not otherwise been paid and are not expected to be paid through any other source, must be submitted for review and substantiation.

- There will be automatic reimbursement, without further review, of recurring expenses that match expenses previously approved as to provider and time period so long as the amount is equal to or less than the previously substantiated amount. In contrast, if a transaction exceeds the previously substantiated amount or is with a different provider, then the participant must submit a statement from the provider to substantiate the expense before amounts relating to the increased amount or new provider can be added to the card.

- If a claim that has been reimbursed is subsequently identified as not qualifying for reimbursement, the same Steps noted above under the Health FSA Component will apply.

Electronic payment cards will not be practical for DCAP participants who obtain dependent care services from nannies, babysitters, home day-care providers, or small child-care centers, as these dependent care providers generally do not use electronic payment mechanisms.

Taxation of DCAP Benefits: Generally, Participants will not be taxed on their DCAP Benefits, up to the limits set forth above. However, the Employer cannot guarantee that specific tax consequences will flow from an Employee's participation in the Plan. The tax benefits that a Participant receives depend on the validity of the claims submitted. For example, to qualify for tax-free treatment, the Participant will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with their annual tax return (Form 1040) or a similar form. The Participant must list on Form 2441 the names and taxpayer identification numbers of any persons who provided them with dependent care services during the calendar year for which they have claimed a tax-free reimbursement. If a Participant is reimbursed for a claim that is later determined to not be for Dependent Care Expenses, they will be required to repay the amount. Ultimately, it is the Participant's responsibility to determine whether each payment to them under this Plan is excludable for tax purposes. A Participant may wish to consult a tax advisor.

Dependent Care Credit: A Participant may not claim any other tax benefit for the tax-free amounts received by them under this Plan, although the *balance* of a Participant's Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Code § 21 *(Dependent Care Credit)* (e.g., if a Participant elects $3,000 of coverage under the DCAP and is reimbursed $3,000, but they had Dependent Care Expenses totaling $5,000, they could count the excess $2,000 when calculating the Dependent Care Credit). Note: the amount of any Dependent Care Credit they may have available will be offset by any DCAP Benefits received under the Plan.

As described above, the Dependent Care Credit is an allowance for a percentage of an individual's annual Dependent Care Expenses as a credit against their federal income tax liability under the Code. In determining what the tax credit would be in 2021, the individual may take into account only $3,000 of such expenses for one Dependent, or $6,000 for two or more Dependents. Depending on the individual's adjusted gross income, the percentage could be as much as 35% of their qualifying expenses (to a maximum credit amount of $1,050 for one Dependent or $2,100 for two or more Dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of the individual's adjusted gross income over $15,000. For taxpayers with adjusted gross income over $43,000, the credit percentage is limited to 20%.

Generally, if an individual is in one of the lower income tax brackets, they might come out ahead by not participating in the DCAP and by claiming the Dependent Care Credit instead. On the other hand, generally the more income taxes an individual is required to pay, the better it would be tax-wise to participate in the DCAP. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as a person’s tax filing status (e.g., married, single, head of household), number of Dependents, etc., each individual will have to determine their tax position individually in order to make the decision between taxable and tax-free benefits. IRS Form 2441 (Child and Dependent Care Expenses) should be reviewed. An individual may also wish to consult a tax advisor.

For more information about how the Dependent Care Credit works, see IRS Publication No. 503 (“Child and Dependent Care Expenses”).

MID YEAR CHANGE IN EMPLOYEE ELECTIONS

Once an Eligible Employee has elected benefits and any accompanying deductions and the Plan Year has begun, they may **not normally modify or revoke their election** of benefits. The spending accounts selected and the amounts chosen will remain in effect for the entire Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events*. "Change in Election Events" include the following events, as more fully described below: Leaves of Absence, including FMLA leave (described in the "FMLA Leave and Non-FMLA Leave" section); Change in Status; certain judgments, decrees and orders; Medicare and Medicaid; Change in Cost; and Change in Coverage. (Changes in *Status, Cost* and *Coverage* are defined below). However, the Change in Election Events do not apply for all Benefits - exclusions are described below for each such Event.

For the 2021 plan year, a special one-time opportunity to make mid-year elections changes for Health FSA and DCAP benefits will be permitted on a prospective basis between June 15, 2021 and July 15, 2021 to allow eligible employees and participants to:

1. Revoke an election, make a new election, or decrease or increase an existing election applicable to a Health FSA; and
2. Revoke an election, make a new election, or decrease or increase an existing election applicable to DCAP.

The new elections will be effective for August 1, 2021 payroll.

If a Change in Election Event (including a Change in Status) occurs, the Participant must inform the Contract Administrator and complete a new Plan Enrollment Form within 30 days of the occurrence.

1. Leaves of Absence. *(Applies to Health FSA and DCAP Benefits).* A Participant may change an election under the Plan upon FMLA and non-FMLA leave (described in the "FMLA Leave and Non-FMLA Leave" section).

2. Change in Status. *(Applies to Health FSA Benefits as Limited Below and DCAP Benefits as Limited Below.)* If one or more of the following Changes in Status occur, the Participant may revoke their old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

1. change in marital status, including marriage, death of Spouse, divorce, legal separation or annulment; or

2. change in the number of Dependents, including birth, adoption, placement for adoption or death of a Dependent; or

3. change in employment status, including termination or commencement of employment of the Participant, Spouse or Dependent; or

4. changes in work schedule, including an increase or decrease in the number of hours of employment by the Participant, Spouse or Dependent, including a switch between full-time and part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence, or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit; or

5. change in which the Dependent satisfies or ceases to satisfy the requirements for Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, Student status or any similar circumstances as provided under the accident or health plan under which the Participant receives coverage; or

6. change in the place of residence or worksite of the Participant, Spouse or Dependent.

3. Change in Status - Other Requirements. *(Applies to Health FSA Benefits as Limited Below and to DCAP Benefits.)* If a Participant wishes to change their election based on a Change in Status, they must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses for the dependent care tax exclusion). Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of the Participant's Spouse, divorce, legal separation, or annulment; death of the Participant's Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or the Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage on account of attaining a certain age, etc. In addition, the Participant must also satisfy the following specific requirements in order to alter their election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (here, the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving the Participant's divorce, annulment or legal separation from the Participant's Spouse, the death of the Participant's Spouse or Dependent, or the Dependent's ceasing to satisfy the eligibility requirements for coverage, the Participant may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than the Participant's Spouse involved in the divorce, annulment, or legal separation, the Participant's deceased Spouse or Dependent, or the Participant's Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which the Participant, their Spouse, or their Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in the Participant's marital status or a change in the Participant's, their Spouse's, or their Dependent's employment status, the Participant's election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only if* coverage for that individual becomes effective or is increased under the other employer's plan.

- *DCAP Benefits.* With respect to the DCAP Benefits, the Participant may change or terminate their election with respect to a Change in Status event only if (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under an employer's Plan; or (2) the Participant's election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce their salary by $2,000 during a plan year to fund dependent care coverage for their daughter. In the middle of the plan year when the daughter turns 13 years old, however, they are no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

4. **Certain Judgments, Decrees and Orders**. *(Applies to Health FSA Benefits, but Not to DCAP Benefits.)* If a judgment, decree or order from a divorce, separation, annulment or custody change requires the Participant's Dependent child (including a foster child who is the Participant's Dependent) to be covered under the Plan, the Participant may change their election to provide coverage for the Dependent child. If the Order requires that another individual (such as the Participant's former Spouse) cover the Dependent child, then the Participant may change their election to revoke coverage for the child.

5. **Medicare or Medicaid**. *(Applies to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If the Participant, their Spouse, or a Dependent becomes entitled to Medicare or Medicaid, the Participant's Health FSA coverage may be canceled completely but not reduced. Similarly, if the Participant, their Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may begin or increase Health FSA coverage.

6. **Change in Cost.** (Applies *to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If there is a significant increase in the cost in the Dependent Care Expenses of the Participant during the Plan Year and such change is imposed by a dependent care provider who is not the Participant's relative, the Participant may choose to do any of the following: (a) make a corresponding increase in their contributions; (b) revoke their election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of their Spouse's employer; or (c) drop their coverage, but *only* if there is no option available under the Plan that provides similar coverage.

7. **Change in Coverage.** *(Applies to DCAP Benefits, but Not to Health FSA Benefits.)* The Participant may make a prospective election change, that is on account of and corresponds with a change by the Participant's dependent care service provider. For example: (a) if a Participant terminates one dependent care service provider and hires a new dependent care service provider or the dependent care service provider's hours of service change, the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

8. **Medicaid or CHIP.** *(Applies to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If a Participant's, their Spouse's, or a Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or if a Participant, Spouse or Dependent becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP, the Participant may begin or increase Health FSA coverage. The Participant must inform the Contract Administrator and complete a new Plan Enrollment Form within 60 days of the occurrence. The effective date will be the first day of the month following the date that the Participant's request is received.

Additionally, the Plan Administrator may modify the Participant's election(s) downward during the Plan Year if the Participant is a key Employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

FMLA LEAVE AND NON-FMLA LEAVE

FMLA Leave of Absence: If the Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by FMLA, the Employer will continue to maintain the Participant's Health FSA Benefits on the same terms and conditions as if the Participant were still active. The Employer may elect to continue all Health FSA Benefits coverage for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant will pay their share of the premiums by the method normally used during any paid leave (for example, on a Salary Reduction basis if that is what was used before the FMLA leave began).

If the Participant is going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and they opt to continue their Health FSA Benefits, then the Participant may pay their share of the premium in one of three ways: (1) with after-tax dollars while on leave; (2) with pre-tax dollars to the extent he receives Compensation during the leave, or by pre-paying all or a portion of their share of the premium for the expected duration of the leave on a Salary Reduction basis out of their pre-leave Compensation, including unused sick days and vacation days (to pre-pay in advance, the Participant must make a special election before such Compensation would normally be available to them (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year)); or (3) by other arrangements agreed upon between the Participant and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from the Participant's Compensation upon their return from leave).

If the Employer requires all Participants to continue Health FSA Benefits during the unpaid FMLA leave, the Participant may discontinue paying their share of the required premium until their return from leave. Upon returning from leave, the Participant must pay their share of any required premiums that they did not pay during the leave. Payment for the Participant's share will be withheld from their Compensation either on a pre-tax or after-tax basis, as the Participant and the Plan Administrator may agree.

If the Participant's Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), the Participant will be entitled to re-enter such Benefits, as applicable, upon return from such leave on the same basis as they were participating in the Plan before the leave, or otherwise required by the FMLA. The Participant is entitled to have coverage for such benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if the Participant's coverage ceased they will be entitled to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If the Participant elects pro-rata coverage, the amount withheld from their Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If the Participant is commencing or returning from FMLA leave, their election for non-health benefits (here, DCAP Benefits) will be treated in the same way as under their Employer's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will, upon returning from leave, be required to pay the premiums not paid by the Participant during leave. Payment will be withheld from the Participant's Compensation either on a Salary Reduction basis or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence: If the Participant goes on an unpaid leave of absence that does not affect eligibility, then they will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator.

AVAILABILITY OF FUNDS

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

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

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

(c) *Available Amount Not Based on Credited Amount.* The amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such negative amount shall never exceed the maximum dollar amount of annual benefits elected by the Participant under this Plan.

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

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

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

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

FORFEITURES

The Participant will forfeit any amount allocated to their Health FSA Account or DCAP Account if that amount has not been applied to Health FSA Benefits or DCAP Benefits for any Plan Year by the Plan's Run-out Period for which the election was effective. For this reason it is very important that accurate predictions are used to determine a Participant's annual out-of-pocket expenses for the spending account(s) selected. The availability of a carryover amount reduces but does not eliminate the potential for forfeitures. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money.

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

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

TERMINATION OF PARTICIPATION

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

- the expiration of the Period of Coverage for which the employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the employee elects to continue participating);

- the termination of this Plan;

- the date on which the employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year); or

- the date the Participant revokes their election under a circumstance when such change is permitted under the terms of this Plan.

Termination of participation in this Plan will automatically revoke the Participant's elections.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Employer may direct. If an Employee remains active but is no longer eligible, contributions to the selected reimbursement account will cease, but the Employee may submit eligible expenses against the current balance through the end of the Plan Year.

This section will be applied and administered consistent with such further rights a Participant and their Dependents may acquire pursuant to Code § 4980B.

TERMINATION OF EMPLOYMENT

If a Participant leaves employment of University of Vermont during the Plan Year, their rights to their Accounts will be determined in the following manner:

- They will remain covered by the benefit programs for the period for which payroll deductions have been paid prior to their termination of employment.

- They will be able to request reimbursement for Dependent Care Expenses for up to ninety (90) days after their termination. Dependent Care Expenses must have been incurred prior to their date of termination. For the 2021 plan year, participants who terminate will be allowed to spend down any remaining dependent care balances on claims incurred after their termination date through the end of the plan year in which participation ended.

- They will be able to request reimbursement for Medical Care Expenses for up to ninety (90) days after their termination. Medical Care Expenses must have been incurred prior to their date of termination. For the 2021 plan year, participants who terminate will be allowed to spend down any remaining medical care expense balances on claims incurred after their termination date through the end of the plan year in which participation ended.

By law, a Participant, Participant's Spouse and their Dependents may be entitled to continuation of health care coverage. The Plan Administrator will inform a Participant of these rights if termination of employment occurs.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect continuation coverage under the Plan when their coverage terminates due to a *Qualifying Event*. This right is protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. University of Vermont is subject to COBRA.

"Continuation Coverage" means the Participant's right, or their Spouse's and Dependents' right, to continue the same coverage under any component medical benefit plan (here, the Health FSA Benefits) that was in place the day before a Qualifying Event if participation by the Participant (including their Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event.

A Qualifying Event is:

- termination of the Participant's employment (other than by reason of gross misconduct), or reduction of their work hours;
- Participant's death;
- divorce or legal separation from the Participant's Spouse;
- Participant's becoming entitled to receive Medicare benefits; or
- Dependent's ceasing to be a Dependent.

Certain Participants with Health FSA Benefits will be eligible for COBRA Continuation Coverage if they have positive Health FSA Account balances at the time of a Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). The Participant will be notified if they are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event Occurs, COBRA coverage for the Health FSA Account will cease at the end of the year and cannot be continued for the next Plan Year. Premiums for such coverage will be paid by the Participant on an after-tax basis unless permitted otherwise by the Plan Administrator on a uniform and consistent basis (but not beyond the current Plan Year).

COBRA Continuation Coverage is subject to the following rules and procedures:

1. The Employer must notify the Contract Administrator of an employment-related Qualifying Event within thirty (30) days of the event.
2. The Qualified Beneficiary must notify the Plan Administrator of a non-employment-related Qualifying Event within sixty (60) days of the event.
3. The Plan Administrator must notify the Qualified Beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Plan Administrator is notified of a Qualifying Event.
4. The Qualified Beneficiary has sixty (60) days from the date of the written notice or Qualifying Event, whichever is later, to notify the Plan Administrator of their decision to elect COBRA Continuation Coverage.

5. COBRA Continuation Coverage will begin on the day following the Qualifying Event.

6. COBRA Continuation Coverage will be identical to the coverage provided under the Plan.

7. To receive COBRA Continuation Coverage, no evidence of insurability will be required, but a monthly premium will be charged.

8. The monthly premium will be 102% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA Continuation Coverage.

9. The initial premium payment is due within forty-five (45) days of electing COBRA Continuation Coverage. The payment must cover all premiums due from the date of the Qualifying Event.

10. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Qualified Beneficiaries will be able to obtain COBRA Continuation Coverage for a maximum term of:

1. Eighteen (18) months following the date of termination of the Participant's employment or a reduction in the Participant's hours of employment resulting in the loss of coverage.

2. The eighteen (18) months may be extended to twenty-nine (29) months following the date of termination of the Participant's employment or a reduction in the Participant's hours of employment resulting in the loss of coverage if any Qualified Beneficiary is disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at the time of the Qualifying Event **or** becomes disabled within sixty (60) days of the Qualifying Event. To qualify for the extension, the disabled individual must submit a copy of the social security disability determination notice within sixty (60) days of such notice. Beginning with the nineteenth (19th) month, the established COBRA premium will be increased to 150% of the applicable premium for the current plan benefits.

3. Qualified Beneficiaries may continue coverage for up to thirty-six (36) months from the date of the original Qualifying Event for COBRA coverage should the Participant die, become legally separated, divorced, Medicare eligible, or should the Dependent lose Dependent status before the expiration of the eighteen (18) months.

In no event will COBRA Continuation Coverage continue beyond thirty-six (36) months from the date of the original Qualifying Event.

Covered Dependents will be able to obtain COBRA Continuation Coverage for a maximum term of:

1. Thirty-six (36) months following the date of the Participant's death, legal separation, divorce, or the Dependent's loss of Dependent status.

COBRA Continuation Coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its employees.

2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.

3. The person who has elected COBRA coverage becomes entitled to Medicare benefits.

4. The Qualified Beneficiary who has elected COBRA coverage becomes covered under another group health plan.

5. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled.

CLAIM FILING PROCEDURES

Written notice of the Participant's or the Dependent's claim (proof of claim) must be given to the Contract Administrator as soon as is reasonably possible but prior to the end of the Run-out Period, which is ninety (90) days after the end of the Plan Year. Claims submitted after the Run-out Period will be denied.

Participants will be permitted to apply unused Health FSA and DCAP amounts remaining as of the end of the 2020 plan year to pay or reimburse expenses incurred through December 31, 2021.

For the 2021 plan year, participants will be permitted to apply unused Health FSA and DCAP amounts remaining as of the end of a plan year to pay or reimburse expenses incurred through December 31, 2022.

Filing a Claim:

To obtain benefits from a Health FSA Account or DCAP Account, a Flexible Benefits Claim Form must be submitted, along with proof of expense, as described herein. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all Health FSA Reimbursement and DCAP Reimbursement claims to:

Employee Benefit Plan Administration (EBPA)
P.O. Box 1140
Exeter, NH 03833-1140
(603) 778-7106 or (888) 678-3457

[Should the Participant have any questions, please feel free to call or write to the Contract Administrator.]

CLAIM REVIEW PROCEDURES

Denial of Claims:

If (a) a claim for reimbursement under the Health FSA or DCAP Component of the Plan is wholly or partially denied, or (b) the Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to the Participant's coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Plan document), then the claims procedure described below will apply.

If the Participant's claim is denied in whole or in part, the Participant will be notified in writing by the Plan Administrator within 10 days of the date the Plan Administrator received the Participant's Claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete the extension notice will also specifically describe the required information, will allow the Participant 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the Participant's claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for the Participant to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if the Participant wishes to appeal the Plan Administrator's decision, including the Participant's right to submit written comments and have them considered, their right to review (upon request and at no charge) relevant documents and other information, and their right to file suit with respect to any adverse determination after appeal of the participant's claim.

Appeals by Participant. If the Participant's claim is denied in whole or part, the Participant (or their authorized representative) may request review upon written application to the *Committee* (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). The Participant's appeal must be made in writing within 180 days of the Participant's receipt of the notice that the claim was denied. If the Participant does not appeal on time, they will lose the right to appeal the denial and the right to file suit in court. The Participant's written appeal should state the reasons that they feel their claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support their claim. The Participant will have the opportunity to ask additional questions and make written comments, and the Participant may review (upon request and at no charge) documents and other information relevant to their appeal.

Decision on Review. The Participant's appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives the Participant's request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the Participant's appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the Participant's appeal will be provided. If the decision on review affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

a. the specific reasons for the decision on review;

b. the specific Plan provision(s) on which the decision is based;

c. a statement of the Participant's right to review, (upon request and at no charge) relevant documents and other information;

d. if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.; and

e. a statement of the Participant's right to bring suit.

MISCELLANEOUS PROVISIONS

Future of the Flexible Benefits Plan: The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which an Employee was entitled before the date of the amendment or termination.

Insurance Contracts: Any monies refunded to the Employer, due to actuarial error in the rate calculation, will be the property of and retained by the Employer.

Classification and Funding: This Plan is classified as a Code § 125 welfare benefits plan by the Department of Labor and is funded by Employer and Employee contributions.

Not a Contract of Employment: No provision of the Plan is to be considered a contract of employment between an Employee and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all Employees, Dependents, and beneficiaries.

Right of Recovery: Whenever the Contract Administrator has allowed benefits to be paid by this Plan which have been paid or should have been paid by any other plan, or which were erroneously paid, the Contract Administrator will have the right to recover to the extent of such excess payments from the appropriate party.

Discharge: Any payment by the Contract Administrator in accordance with the terms and provisions contained herein will discharge the Employer from all future liability to the extent of the payments so made.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly carry out the provisions of this Plan. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Privacy Notice, which has been distributed to each Employee covered under the Health FSA Component.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, please contact the Privacy Official in the Plan Administrator's office.

Qualified Medical Child Support Order: This Plan extends benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or their newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998: The Women's Health and Cancer Rights Act of 1998 requires the Plan sponsor to notify Participants in the Plan of their rights related to benefits provided through the Plan in connection with a mastectomy (where applicable). Participants or Dependents under this Plan have rights for coverage to be provided in a manner determined in consultation with their attending physician for the following services in connection with a mastectomy:

A. all stages of reconstruction of the breast on which the mastectomy is performed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. prostheses and treatment of physical complications of the mastectomy, including lymphedema.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan.

"Account(s)" means the Health FSA Accounts and the DCAP Accounts described in the "Availability of Funds" section.

"Benefits" means the Health FSA Benefits and the DCAP Benefits offered under the Plan.

"Change in Status" has the meaning described in the "Mid Year Change in Employee Elections" section.

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

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

"Compensation" means the total Form W-2 compensation for federal income tax withholding purposes paid by the Employer to an Employee for services performed, determined prior to (a) any Salary Reduction election under this Plan, (b) any salary reduction election under any other Code § 125 cafeteria plan, and (c) any compensation reduction under any Code § 132(f) plan; but determined after (d) any elective salary deferral contributions under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement.

"Contract Administrator" means the third-party claims administrator, hired by the Employer sponsoring the Plan to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to Participants and/or providers;

2. remitting benefit payments for covered expenses under the Plan to Participants and/or providers; and

3. reviewing all claims appeals.

"DCAP" means dependent care assistance program.

"DCAP Account" means the account described in the "Availability of Funds" section.

"DCAP Benefits" has the meaning described in the "DCAP Component" section.

"DCAP Component" means the Component of this Plan described in the "DCAP Component" section.

"Dependent" means any individual who is a dependent, up to age twenty-six (26), of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of the Health FSA Component, (i) a dependent is defined in Code § 152 without regard to subsections (b)(1), (b)(2) and (d)(1)(B); and (ii), any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year) is treated as a dependent of both parents; and (b) for purposes of the DCAP Component, a dependent means a qualifying individual as defined in Code § 21(b)(1) with respect to the Participant, and in the case of divorced parents, a qualifying individual who is a child shall, as provided in Code § 21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code § 152(e)(1)) and shall not be treated as a qualifying individual with respect to the noncustodial parent.

"Dependent Care Expenses" has the meaning described in the "DCAP Component" section.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but does not include (a) any amount received pursuant to any DCAP under Code § 129 or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received as a pension or annuity or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in the "General Information" section.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in the "General Information" section.

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

"Employer" means University of Vermont, and any Related Employer which adopts this Plan with the approval of University of Vermont. Related Employers who have adopted this Plan, if any, are listed in the "General Information" section. However, for purposes of the "Future of the Flexible Benefits Plan" paragraph in the "Miscellaneous Provisions" section, "Employer" means only University of Vermont.

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

"Flexible Benefits Claim Form" means the form submitted to the Contract Administrator to obtain benefits from a Health FSA Account or DCAP Account.

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

"Health FSA" means the health flexible spending arrangement.

"Health FSA Account" means the account described in the "Availability of Funds" section.

"Health FSA Benefits" has the meaning described in the "Health FSA Component" section.

"Health FSA Component" means the Component of this Plan described in the "Health FSA Component" section.

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

"Medical Care Expense" has the meaning defined in the "Health FSA Component" section.

"Open Enrollment Period" with respect to a Plan Year means the 30 days immediately preceding such Plan Year, or other period prescribed by the Administrator.

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

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the "Eligibility and Enrollment" section; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the "Termination of Employment" section.

"Plan" means the University of Vermont Flexible Benefits Plan as set forth herein and as amended from time to time.

"Plan Administrator" means University of Vermont or the person, persons or business organization designated by the Board of Directors of the Company.

"Plan Enrollment Form" means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Health FSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Plan Year" means the calendar year (i.e., the twelve-month period commencing January 1 and ending on December 31).

"Premium" means the amount contributed to pay for the cost of Benefits, as calculated under the "Health FSA Component" and "DCAP Component" sections.

"QMCSO" means a qualified medical child support order.

"Qualifying Dependent Care Services" has the meaning described in the "DCAP Component" section.

"Qualifying Individual" has the meaning described in the "DCAP Component" section.

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

"Run-out Period" means the ninety (90) day period after the Plan Year during which a Participant may submit claims for reimbursement from their Health FSA or DCAP Accounts.

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

"Spouse" means an individual who is a Participant's same or opposite-sex spouse, provided that such individual is legally recognized as the eligible employee's spouse in any jurisdiction (such as a State or foreign country), and even if the individual is not recognized as the Participant's spouse in the Participant's State of residence (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCAP Component, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Participant.

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

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This document, known as the University of Vermont Flexible Benefits Plan, is hereby executed:

_____, _____ on _____
(City) (State) (Date)

BY: Richard H Cate _____

Digitally signed by Richard H Cate
DN: cn=Richard H Cate, o=University of Vermont and State Agricultural College, ou, email=rcate@uvm.edu, c=US
Date: 2021.06.07 17:05:27 -04'00'

TITLE: _____