

**New Mexico State University**

**Cafeteria Plan**

**PREAMBLE AND EXECUTION**

WHEREAS, New Mexico State University (“the University”) maintains New Mexico State University’s Cafeteria Plan; and

WHEREAS, the University desires to amend and restate the plan;

NOW, THEREFORE by virtue and in exercise of the amending power reserved to the University as the authorized representative of the Board of Regents and pursuant to the authority delegated to the undersigned agent of the University by policies adopted by its Board of Regents, the New Mexico State University Cafeteria Plan (The “Plan”) is hereby amended and restated in its entirety.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be amended by its duly authorized officer this 13 day of July, 2015.

New Mexico State University

By

  
Title ASST-VP FOR HUMAN RESOURCES

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**ARTICLE I**  
**PLAN ESTABLISHMENT**

**1.1 Effective Date**

New Mexico State University Cafeteria Plan ("the Plan") is amended and restated, effective as of January 1, 2015.

**1.2 Purpose**

The Plan is created exclusively for Employees, as defined in Section 2.10. The Plan's purpose is to provide Covered Employees, as defined in Section 2.6, the means to exchange all or part of their compensation, for other Plan benefits they select.

**1.3 Qualification**

The Plan is intended to qualify as a cafeteria plan under section 125 of the Internal Revenue Code of 1986, as amended (the "Code"); the Cafeteria Plan is not intended to be an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of Department of Treasury Proposed Regulations section 1.125-1(c).

The Dependent Care Spending Account Plan, as defined in Section 2.7 and set forth in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance program under section 129 of the Code. Appendix A is intended to satisfy the written plan document requirement of Code section 129(d)(1).

The Health Care Spending Account Plan, as defined in Section 2.13 and set forth in Appendix B, is part of this Plan. The Health Care Spending Account Plan is intended to qualify as a health plan under section 105(e) of the Code. Appendix B is also intended to satisfy the written plan document requirement of Code regulation section 1.105-11(b)(1)(i).

Notwithstanding anything in this document to the contrary, the Plan, the Dependent Care Spending Account Plan, and the Health Care Spending Account Plan are not subject to ERISA. Exception for section 3.3(F), relating to Qualified Medical Child Support Orders, all references to ERISA are for purposes of reference and analogy only and shall not create any binding obligations on New Mexico State University.

**1.4 Duration**

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Employer, as defined in Section 2.11, in its sole discretion and in accordance with the provisions of Article VIII may amend or terminate the Plan or any provision of the Plan at any time.



**ARTICLE II**  
**DEFINITIONS**

The following words and phrases, when capitalized, shall have the following meanings.

**2.1 Board of Regents**

Board of Regents means the persons and their successors, appointed or elected to manage and direct the affairs of the University.

**2.2 Change in Status**

Change in Status means:

- A. a “special enrollment” event under HIPAA,
- B. the Covered Employee's marriage, divorce, legal separation or annulment,
- C. dissolution of domestic partnership,
- D. the birth, adoption, placement for adoption, or change in dependency or custody of a Covered Employee's Dependent child,
- E. the death of the Employee's Spouse or Dependent child,
- F. a change in employment status by the Covered Employee, Spouse or Dependent, including commencement or termination of employment, a change in work shift, a change in worksite, a reduction or increase in hours of employment including changing from part-time to full-time employment status, a strike or lockout,
- G. commencement of an unpaid leave of absence by the Employee, Spouse or Dependent,
- H. return from an unpaid leave of absence pursuant to the FMLA by the Employee,
- I. a change in worksite or personal residence resulting in eligibility or loss of eligibility of coverage for the Covered Employee, Spouse or Dependent under any health maintenance organization offered through the Plan,
- J. a change in legal custody (including the issuance of a qualified medical child support order) that affects the child’s eligibility for coverage under this Plan or the plan of the child's other parent,
- K. entitlement or loss of entitlement to Medicare or Medicaid by an Employee, Spouse, or Dependent,

- L. attainment by Dependent child of limiting age for a benefit provided under this Plan,
- M. loss of “Qualifying Individual” status, as defined in Section 2.9 of the Dependent Care Spending Account Plan,
- N. a change in status event affecting a nondependent child who has not attained age 27 as of the end of the taxable year, including becoming newly eligible for a benefit provided under this Plan, beyond the date on which the child would otherwise have lost coverage, or
- O. any other event the Plan Administrator determines permits revocation of an election without violating the Code.

**2.3 Claim Administrator**

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

**2.4 Code**

Code means Internal Revenue Code of 1986, as amended, and regulations issued thereunder or pursuant thereto.

**2.5 University**

University means New Mexico State University, a public entity or non-profit corporation, and any successor, by merger or otherwise.

**2.6 Covered Employee**

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III and who has made an election to participate in the benefits described in Section 4.3.

**2.7 Dependent**

To the extent paid through this Plan by Salary Reduction Contributions, or, the Covered Employee’s child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

Dependent means a Covered Employee’s dependent as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) or, effective January 1, 2012, for health benefits the Covered Employee’s child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

## **2.8 Dependent Care Spending Account Plan**

Dependent Care Spending Account Plan means the plan set forth in Appendix A.

## **2.9 Effective Date**

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2015. The original effective date was August 1, 2003.

## **2.10 Employee**

For purposes of this Plan only, the term Employee means a person currently performing personal services under his or her Employer's control in any job category in a "Regular" or a "Non-Regular Term Appointment" classification (as such terms are defined in applicable New Mexico State University policies).

The term *Employee* includes, but is not limited to, a person who is:

- A. a leased employee, as defined in Code section 414(n),
- B. a nonresident alien who receives no earned income (within the meaning of Code section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3),
- C. collectively bargained employees.

The term *Employee* does not mean:

- D. a self-employed individual, as defined in Code section 401(c)(1)(A),
- E. a member of the Board of Regents who is not otherwise an employee,
- F. a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor, and
- G. a person whom the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

## **2.11 Employer**

Employer means the University and any subsidiary or affiliated organization and any successor(s) of any of them which, with the approval of the University, and subject to such conditions as the University may impose, adopts the Plan.

For purposes of satisfying the nondiscrimination requirements of Code section 125(b), section 105(h) and 129(d), the term “Employer” shall include any other corporation or other business entity which must be aggregated with the Employer under section 414(b), (c), (m) or (o) of the Code, but only for such period of time when the Employer or such other corporation or other business entity must be aggregated as aforesaid.

**2.12 FMLA**

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations issued thereunder or pursuant thereto.

**2.13 Health Care Spending Account Plan**

Health Care Spending Account Plan is the plan set forth in Appendix B.

**2.14 HIPAA**

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder or pursuant thereto.

**2.15 Plan**

Plan means New Mexico State University Cafeteria Plan as herein set forth and as amended from time to time.

**2.16 Plan Administrator**

Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

**2.17 Plan Year**

Plan Year means the 12-month period beginning January 1 and ending December 31. Coverage paid for spending accounts means the 12-month period beginning January 1 and ending December 31.

**2.18 Salary Deduction Agreement**

Salary Deduction Agreement means the authorization to the Employer by the Employee to reduce such Employee’s pay by an amount on an after-tax basis for selected Plan benefits.

**2.19 Salary Deduction Contributions**

Salary Deduction Contributions means the contributions taken from the Covered Employee’s salary on an after-tax basis, pursuant to a Salary Deduction Agreement.

**2.20 Salary Reduction Agreement**

Salary Reduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Plan benefits.

**2.21 Salary Reduction Contributions**

Salary Reduction Contributions means the contributions taken from the Covered Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

**2.22 Spouse**

Spouse means, for purposes of this Plan only, the Covered Employee's legal spouse as defined under the law of the state or jurisdiction in which the marriage was performed.

## ARTICLE III

### ELIGIBILITY, PARTICIPATION AND COVERAGE

#### 3.1 Eligibility

- A. An Employee shall become eligible for Plan participation on the later of the Effective Date or the date the applicable benefit is effective.
- B. The following Employees are not eligible to participate in the Plan:
  - 1. Employees who are hired into a classification other than a “Regular” or a “Non-Regular Term Appointment” classification (as such terms are defined in applicable New Mexico State University policies); Employees who are hired on a *seasonal* basis, as such classification is defined in applicable New Mexico State University policies; Leased employees, as defined in Code section 414(n);
  - 2. Student employees and graduate assistants; Employees in an employee unit covered by a collective bargaining agreement between Employee representatives and one or more Employers if this Plan’s benefits were the subject of good faith bargaining between the Employee representatives and the Employers, unless such agreement provides for coverage for such bargaining employees in the Plan; and
  - 3. Nonresident aliens who receive no earned income (within the meaning of the Code section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code section 861(a)(3).

#### 3.2 Participation

Employees become Plan participants on the date they satisfy the eligibility requirements of Section 3.1 and the enrollment and election requirements of Section 5.1.

#### 3.3 Coverage

- A. Date Coverage Begins

Employees become Covered Employees as of the date specified in Section 5.1(C)(1).

B. Coverage During Leave of Absence

1. Paid Leave

During a paid leave of absence, a Covered Employee continues to participate in the premium payment benefits he or she elected, but may elect to voluntarily terminate coverage during the leave.

2. Unpaid Leave

Except as otherwise provided below, Plan coverage for a Covered Employee on an approved unpaid leave of absence is suspended on the last date of coverage for which a premium payment benefit has been paid. The terms of the plan to which the participant's selected premium payment benefits were paid control whether and to what extent coverage and benefits under that plan continue. To the extent the Covered Employee may continue coverage during an unpaid leave, the Covered Employee is required to pay for coverage on an after-tax basis.

If the unpaid leave of absence is taken pursuant to FMLA, Covered Employees may elect to continue participation in premium payment benefits described in Section 4.3(A-G) by (i) paying premium payment benefits during the FMLA leave on an after-tax basis, or to the extent possible on a before-tax basis, or (ii) paying on a before-tax basis upon return from the leave the premium payment benefits for coverage during the leave, and adjusting the Salary Reduction Contribution accordingly for the balance of the Plan Year. Benefits described in Section 4.3(D) are suspended.

With respect to premium payment benefits described in Section 4.3(E) if the Covered Employee elects to revoke such coverage during the unpaid leave, no expenses incurred during the leave shall be reimbursed. Upon return from an unpaid leave taken pursuant to FMLA, the Employee can elect to be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year, unless an election change is otherwise authorized under Section 5.1(F)(3)(b), (d) or (e).

C. Date Coverage Ceases

Plan coverage ceases on the earliest of:

1. the last day of the pay period the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively, or the end of the pay period in which the employee terms, retires, voluntarily cancels or cancels due to a qualifying event.

2. except where participation continues during an unpaid leave of absence, the last day of the last pay period for which a Covered Employee makes a Salary Reduction Contribution or Salary Deduction Contribution as required for Plan participation,
3. the effective date of a Plan amendment that terminates coverage for the Covered Employee's job category, or
4. the date the Plan terminates.

D. Effect of Terminated Coverage

Termination of coverage automatically cancels a Covered Employee's Covered Employee's Salary Reduction Agreement and Salary Deduction Agreement on the date coverage terminates. The plan's terms governing the Covered Employee's selected premium payment benefit control whether and to what extent coverage and benefits under that plan continue.

E. Reinstatement of Coverage

1. If Previously Suspended

A Covered Employee who returns to an Employer's service during the same Plan Year that he or she took an unpaid leave of absence pursuant to the FMLA will have reinstated automatically the benefit elections in effect when Plan coverage was suspended provided such benefits continue to be provided by the University. If an unpaid leave of absence was taken in accordance with FMLA, such Covered Employee may reinstate his or her election and Salary Reduction Agreement for the remainder of the Plan Year if participation has not continued pursuant to Section 3.3(B). In all other cases of suspended coverage due to non-FMLA unpaid leave of absence, the Covered Employee may not make new benefit elections for pre-tax benefit elections for the remainder of the Plan Year. Whether or not evidence of insurability is required for any changes made to after-tax benefit elections will be governed by the applicable health and/or welfare benefit plan(s) listed in Section 4.3.

2. If Previously Terminated

A former Covered Employee who returns to an Employer's service shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within the pay period following termination of benefits, he shall have his prior benefit elections reinstated without a coverage gap and may not make any new benefit elections for the remainder of the Plan Year, except as described in Section 5.1(F)(3). The



above rule shall not apply and the rehired Employee shall be eligible to make new elections for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.1(F)(3).

F. Coverage under the Family and Medical Leave Act and Section 609 of ERISA

1. Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with FMLA, and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

2. Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined under section 609(a) of ERISA or to an adoptive child solely to the extent required by section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with section 609 of ERISA and the rulings and regulations issued thereunder.

3. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section 3.3(F) shall be conditioned upon payment of applicable contributions by the Employee.

G. Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereinafter the "Uniformed Services Act"), an Employee who is a Covered Employee and who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of the required premiums.

This Section shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

**ARTICLE IV**  
**BENEFITS**

**4.1 Benefit Options**

As a condition of Plan participation, Covered Employees must elect either:

- A. to receive the full unreduced compensation benefit described in Section 4.2, or
- B. to forego all or part of the unreduced compensation benefit described in Section 4.2 and make before- or after-tax contributions in exchange for one or a combination of premium payment benefits described in Section 4.3.

The Benefits described in Sections 4.3(A-E) may be made either on a before-tax or after-tax basis. The Benefits described in Sections 4.3(F-I) must be paid for on an after-tax basis. Notwithstanding the foregoing, Employee contributions for coverage for domestic partners and the domestic partner's children will be made on an after-tax basis for federal or state tax purposes, as appropriate, through a Salary Deduction Agreement.

**4.2 Unreduced Compensation Benefit**

In lieu of all or some of the premium payment benefits described in Section 4.3 that a Covered Employee otherwise could elect, he or she may elect to receive unreduced compensation in an amount equal to the value of the premium payment benefits not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by not electing a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

**4.3 Benefits**

By electing one or more premium payment benefits, an Employee converts a portion of his or her compensation for the Plan Year into contributions to the plan that governs the selected benefit. That plan's terms, as amended from time to time, govern a Covered Employee's rights and obligations under it. Covered Employees may elect one or more of these benefits:

- A. Medical Premium Payment

A Covered Employee may elect any available coverage level and/or option as the medical premium payment benefit.

B. Dental Premium Payment

A Covered Employee may elect any available coverage level and/or option as the dental premium payment benefit.

C. Vision Premium Payment

A Covered Employee may elect any available coverage level and/or option as the vision premium payment benefit.

D. Dependent Care Spending Account Premium Payment

A Covered Employee may elect any whole dollar annual contribution amount of not less than \$5 per paycheck and not more than \$5,000 annually as the dependent care spending account premium benefit. If the Covered Employee's initial period of participation is less than a full Plan Year, the maximum annual contribution shall be prorated by multiplying the maximum annual contribution by a fraction, the numerator of which is the number of payroll periods of participation and the denominator of which is the total payroll periods in the Plan Year.

E. Health Care Spending Account Premium Payment

A Covered Employee may elect any whole dollar annual contribution amount of not less than \$5 per paycheck and not more than \$2,550 annually, or if less, the maximum amount allowed under Section 125 of the Code, as the health care spending account plan premium benefit. If the Covered Employee's initial period of participation is less than a full Plan Year, the maximum annual contribution shall be prorated by multiplying the maximum annual contribution by a fraction, the numerator of which is the number of payroll periods of participation and the denominator of which is the total payroll periods in the Plan Year.

F. Group Term Life Premium Payment

A Covered Employee may elect any available option as the group term life plan premium payment benefit.

G. Accidental Death & Dismemberment Premium Payment

A Covered Employee may elect any available option as the accidental death & dismemberment plan premium payment benefit.

H. Long-Term Disability Premium Payment

A Covered Employee may elect any available option as the long-term disability premium benefit.

I. Critical Illness Premium Payment

A Covered Employee may elect any available option as the critical illness premium benefit.

The Employer must contribute the amounts corresponding to the value of the benefits that Covered Employees select to the plans governing the Covered Employees' selected benefits. Covered Employees forfeit unused Salary Reduction Contributions and/or Salary Deduction Contributions, if any. Covered Employees may not receive a cash out of Salary Reduction Contributions that are forfeited, nor may Covered Employees apply such forfeitures toward any other Plan benefit.

Notwithstanding the foregoing, a Covered Employee shall not forfeit unused Salary Reduction Contributions applicable to the Health Care Spending Account that do not exceed the lesser of \$500 or the unused balance of such Covered Employee's Health Care Spending Account at the end of the Plan Year (after the claim runout period). But a Covered Employee may elect to carry over up to \$500 or, if less, the unused balance in his or her Health Care Spending Account at the end of the Plan Year to a subsequent Plan Year. Such unused balance cannot be cashed out. Any amounts in excess of \$500 shall be forfeited in the same manner as forfeitures for other Salary Reduction Contributions. Carryover amounts are available even if the Covered Employee does not make a Health Care Spending Account election for the next Plan Year, provided that coverage did not terminate due to a COBRA Qualifying Event (unless IRS guidance otherwise requires).

#### **4.4 Limits for Certain Employees**

Benefits payable under the Plan to each highly compensated participant, as defined in Code section 125(e)(1) or highly compensated individual, as defined in Code section 125(e)(2), shall be limited to the extent necessary to avoid violating Code section 125(b)(1).

Benefits payable under the Plan to each key employee, as defined in Code section 416(i)(1), are limited to the extent necessary to avoid violating Code section 125(b)(2) and with respect to benefits described in Section 4.3(F), Code section 79(d).

Benefits payable under the Plan to each highly compensated individual, as defined in Code Section 105(h)(5) shall be limited to the extent necessary to avoid violating Code Section 105(h)(1) as applicable.

Benefits payable under the Plan to a highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8). The Employer may determine prior to or during a Plan Year that the Salary Reduction Contributions of a highly compensated employee must be reduced to avoid violating Code section 129(d)(8). Any amounts that are in excess of the Code section 129(d)(8) limit shall be returned to a highly compensated employee in the form of taxable compensation.

#### **4.5 Notification of Premium Payment Benefit Amounts**

The University shall provide written notification to eligible Employees of the amount of the premium payment benefits prior to the initial and annual enrollment/election period. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or welfare benefit plan(s) for which a premium payment benefit is available under the Plan. Any such written notification is hereby incorporated by reference and made part of the Plan.

#### **4.6 Application of Other Plans**

Notwithstanding any other provision of the Plan, Covered Employees electing one or more premium payment benefits under the Plan shall be subject to the provisions, conditions, limitations, and exclusions of the health and/or welfare benefit plan(s) listed in Section 4.3 for which they elect the premium payment benefit. Such plans are hereby incorporated by reference to the extent that they apply to the operation of this Plan.

**ARTICLE V**  
**PROCEDURES**

**5.1 Enrollment/Election Procedures**

A. Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions and Salary Deduction Contributions only by filing the appropriate, completed forms or agreements with the Plan Administrator before the deadline described in Section 5.1(C).

B. Annual Enrollment

Varies by plan. The Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year.

C. Deadlines

1. Initial Enrollment/Election

For Employees who become eligible as of the Effective Date, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the first day of the Plan Year to which the enrollment, elections and Salary Reduction Agreement apply.

For Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.1(B), the deadline for enrolling and making initial elections is the 31 day period after the Employee becomes eligible in accordance with Section 3.1. Salary Reduction Agreements and/or Salary Deduction Agreements shall be effective in accordance with the plan provisions, as they vary by plan.

2. Annual Enrollment/Election

For Covered Employees and Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment, elections, and Salary Reduction Agreements and/or Salary Deduction Agreements apply.

D. Missed Deadline Yields Default Election

1. Initial Enrollment

An Employee (other than a Covered Employee) who fails to submit a valid enrollment/election Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.1(A), is deemed to elect the maximum unreduced compensation benefit, described in Section 4.2, unless the Plan Administrator approves a supplemental election, as described in Section 5.1(F)(2).

2. Annual Enrollment

Unless the Plan Administrator approves a supplemental election, as described in Section 5.1(F)(2), a Covered Employee who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.1(A), automatically re-elects the same premium payment benefits then in effect for the next Plan Year, except that participation in the Dependent Care Spending Account Plan and Health Care Spending Account Plan shall be deemed waived for the next Plan Year. The Salary Reduction Contribution and/or Salary Deduction Contribution amounts for the re-elected benefits will be adjusted automatically to reflect any increase or decrease in the premium payment benefit cost.

E. Validity of Enrollment/Elections and Salary Reduction Agreement and/or Salary Deduction Agreement

1. Plan Administrator Approval

Enrollments and elections and Salary Reduction Agreement and/or Salary Deduction Agreement take effect only if valid, as determined by the Plan Administrator. Except for supplemental elections described in Section 5.1(F)(2), the Plan Administrator shall substitute the unreduced compensation benefit, described in Section 4.2, for any invalid premium payment benefit election.

2. Remedial Modification or Rejection

The Plan Administrator may modify or reject any enrollment or election and/or Salary Reduction Agreement and/or Salary Deduction Agreement or take other action the Plan Administrator deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code section 125(b). Any remedial modification, rejection, or other action the Plan Administrator takes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code

section 125(e)(1) and (2), respectively, or key employees, as defined in Code section 416(i)(1).

F. Changing Elections

1. General Rule

All elections (including default elections described in Section 5.1(D)) and Salary Reduction Agreements and/or Salary Deduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.1(F). During annual enrollment, however, Covered Employees may make new benefit elections or change existing ones for the forthcoming Plan Year.

2. Supplemental Elections

Section 5.1(F)(1) notwithstanding, the Plan Administrator may approve a supplemental election to correct an enrollment or election or Salary Reduction Agreement and/or Salary Deduction Agreement that is invalid for any reason if approval would not violate Code section 125.

3. Revocation of Elections

Except as provided in Section 3.3(C), Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements during a Plan Year only in accordance with the provisions described in this Section 5.1(F)(3). Except for changes made in accordance with Section 5.1(F)(3)(g) and, effective April 1, 2009, changes made pursuant to a HIPAA special enrollment due to initial entitlement to state premium assistance under Medicaid or CHIP or loss of entitlement to Medicaid or a state children's health insurance program (CHIP), a Covered Employee must make the change within 31 days of the event giving rise to the election change. In the event of a HIPAA special enrollment due to the loss of Medicaid or a state children's health insurance program (CHIP) or initial entitlement to state premium assistance by an Employee, Spouse or Dependent a Covered Employee will have 60 days from the date of the event to make an election change. Notwithstanding anything in this Section 5.1(F) to the contrary, after-tax elections and Salary Deduction Agreements may be revoked at any time. Further notwithstanding the provisions of this Section 5.1(F), an Employee's or Covered Employee's ability to elect or revoke certain benefit options mid year may be restricted by the terms of the plan governing that benefit option (including any terms pertaining to evidence of insurability).



a. Separation from Service

Covered Employees may revoke elections and Salary Reduction Agreements and/or Salary Deduction Agreements on separating from the Employer's service. Regardless of previous claims or reimbursements, the Plan Administrator must reimburse a Covered Employee for any amounts the Covered Employee already paid for coverage relating to the period after the effective date of termination of coverage.

b. Change in Status

A Covered Employee may revoke any election (including a default election) and make a new one if such revocation and new election are both on account of and necessary or appropriate because of a Change in Status.

Election and salary reduction changes must be consistent with the Change in Status, except for elections made pursuant to the special enrollment provisions of HIPAA.

For purposes of this subparagraph (b), the term consistent means that the Change in Status event must cause the Employee or Employee's Spouse or Dependent children to gain or lose eligibility under an employer-sponsored benefit offered through this Plan or the plan of the Spouse or Dependent. The election shall take effect the first payroll period following receipt by the Plan Administrator of the election change, but not earlier than the date of the Change in Status. With respect to an election change made pursuant to a birth, adoption or placement for adoption of a child, the election change shall take effect as of the birth, adoption or placement for adoption.

The Plan Administrator may require such evidence as it deems necessary to satisfy the consistency requirement imposed by section 125 of the Code.

c. Cost Changes

If the cost of a premium payment benefit increases or decreases during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically make a prospective change to Covered Employees' contributions to reflect the cost of this change.

This opportunity for making new elections does not apply to the Health Care Spending Account Plan and applies to the Dependent Care Spending Account Plan only if a cost increase is imposed by a dependent care provider who is not a relative of the Covered

Employee. For purposes of this subparagraph (c), a “relative” is an individual who is related as described in Code section 152(d)(2) (A) through (G), incorporating the rules of Code sections 152(f)(1)(B) and 152(f)(4). Coverage Changes

(1) Significant curtailment with *loss of coverage*

If coverage offered under the Plan is significantly curtailed to the extent that the Covered Employee experiences a *loss of coverage*, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage, or may revoke existing coverage if no other option providing similar coverage is available. For purposes of this subparagraph (d), a *loss of coverage* means a complete loss of coverage under the benefit option and shall include the elimination of a benefit option, an HMO ceasing to be available where the individual resides, the individual losing all coverage under the option by reason of an overall lifetime or annual limitation, or other fundamental loss of coverage as determined by the Plan Administrator.

(2) Significantly Improved or New Benefit Option

If the coverage offered under the Plan is significantly improved or if a new benefit option is made available under the Plan, then: (A) a Covered Employee who is enrolled in a benefit option other than the new or significantly improved benefit option may change their election on a prospective basis to elect the new or significantly improved benefit option, or (B) a Eligible Employee who had previously elected to waive coverage under a benefit option may elect to enroll on a prospective basis in the new or significantly improved benefit option. The Plan Administrator, in its sole discretion, will determine whether there has been an addition of, or a significant improvement in, a benefit option in accordance with Internal Revenue Service guidance.

d. Loss of Coverage under Another Health Plan

If an Employee, Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Employee may make a new election on a prospective basis for health coverage provided under this Plan, provided such Employee, Spouse or Dependent is otherwise eligible for coverage

under this Plan. For purposes of this subparagraph (f), a governmental or educational institution shall include the following:

- (1) A state children's health program (CHIP) under Title XXI of the Social Security Act,
- (2) A medical program of an Indian Tribal government (as defined in section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization,
- (3) A state health benefits risk pool, or
- (4) A foreign government group health plan.

e. Automatic Adjustment of Election

The election and Salary Reduction Agreement of a Covered Employee who loses a Spouse or Dependent due to death for purposes of a premium payment benefit described in Section 4.3, but fails to make a timely election in accordance with Section 5.1 shall be automatically adjusted.

## 5.2 Claim Procedures

Claims relating to a plan governing a premium payment benefit are reviewable only under that plan's terms.

Claim procedures for the Dependent Care Spending Account shall be as set forth in Article VI of Appendix A.

Claim procedures for the Health Care Spending Account shall be as set forth in Article VII of Appendix B.

**ARTICLE VI**  
**CONTRIBUTIONS AND FUNDING**

**6.1 Contributions**

**A. Employer Contributions**

The Employer shall pay premium payment benefits listed in Section 4.3 to the Employer-sponsored health and welfare plans to which such benefits are payable provided that the Covered Employee shall authorize Salary Reduction Contributions in a corresponding amount pursuant to Section 6.1(B)(2).

Notwithstanding any contrary Plan provision, the Employer is not obligated to contribute to the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

**B. Salary Reduction and/or Salary Deduction Contributions**

As a condition of Plan participation, Employees must agree to direct the Employer to:

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.3, or
2. reduce their compensation and make Salary Reduction Contributions and/or Salary Deduction Contributions to the plan(s) governing their selected premium payment benefits.

Any election of premium payment benefits shall be null and void unless the Employee authorizes a Salary Reduction Agreement and/or a Salary Deduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and/or Salary Deduction Contributions and apply them as directed, except that the Employer may not apply a Salary Reduction Contribution or a Salary Deduction Contribution for a selected premium payment benefit to any other premium payment benefit nor may a Salary Reduction Contribution or a Salary Deduction Contribution be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage. Any such Salary Reduction Agreements and/or a Salary Deduction Agreements are hereby incorporated by reference into the Plan as if set forth in full herein.

C. Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Covered Employees and then from amounts contributed by the Employer.

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Section 4.3(A, B, C, E, F, G, H), the Plan shall accept contributions from such individuals as COBRA premiums.

**6.2 Funding**

The Employer shall establish and carry out, and may revise from time to time, the funding policy for the Plan. The Employer shall make payments provided for in Section 6.1(A) from its general assets. The Employer shall make payments provided for in Section 6.1(B) and (D) by collecting Employee contributions and COBRA contributions and transmitting such amounts to the applicable Employer-sponsored health and welfare benefit plan.

**ARTICLE VII**  
**ADMINISTRATION**

**7.1 Plan Administrator**

The University shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the University shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

**7.2 Plan Administrator's Duties**

The Plan Administrator shall:

- A. manage and carry out the Plan's operation and administration according to the Plan's terms and for Covered Employees' exclusive benefit;
- B. maintain:
  - 1. whatever records and data are necessary or desirable for the Plan's proper operation and administration, and
  - 2. the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;
- C. notify Employees eligible to participate in the Plan of:
  - 1. the Plan's availability and terms,
  - 2. the premium payment benefits available for election,
  - 3. the maximum annual Salary Reduction Contribution and/or Salary Deduction Contribution amounts for each available premium payment benefit, and
  - 4. the procedures for enrolling and making and changing elections;
- D. supply eligible Employees with any forms and agreements they must complete;
- E. prepare and file all annual reports or returns, plan descriptions, financial statements, and other documents required by law or under the Plan's terms; and
- F. record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

### 7.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Board of Regents, the University, the Employer, or the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

- A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;
- B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;
- C. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;
- D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;
- E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;
- F. determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part; provided however, that any claim for benefits under a health and welfare plan shall be determined solely in accordance with the terms of such plan,
- G. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;
- H. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;
- I. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including such amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to

time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

- J. pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

#### **7.4 Finality of Decisions**

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

#### **7.5 Compensation and Bonding of Plan Administrator**

Unless otherwise agreed to by the University, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Section 9.17. Unless otherwise determined by the University or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

#### **7.6 Liability Insurance**

The University may obtain liability coverage at the University's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

#### **7.7 Reserved Powers**

The University reserves the powers, among others:

- A. to adopt the Plan;
- B. to amend, terminate, or merge the Plan according to Article VIII; and
- C. to appoint and remove any Plan Administrator.



## ARTICLE VIII

### AMENDMENT, TERMINATION OR MERGER OF PLAN

#### **8.1 Right to Amend the Plan**

Except as provided in Section 8.3, the University (or its duly authorized representative) expressly reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the duly authorized representative of the University acting in accordance with its regular duties for the University.

#### **8.2 Right to Terminate or Merge the Plan**

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, University (or its duly authorized representative) reserves the unlimited right to terminate or merge the Plan. Any termination or merger of the Plan shall be in writing and shall be adopted by the duly authorized representative of the University acting in accordance with its regular duties for the University.

#### **8.3 Effect of Amendment, Termination or Merger**

Any amendment, termination or merger of the Plan shall be effective at such date as the University shall determine except that no amendment, termination or merger may be retroactive unless remedial to comply with a law or regulatory requirement the University or the Plan is subject to.

**ARTICLE IX**  
**MISCELLANEOUS**

**9.1 No Employment Rights**

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the University or their shareholders, Regents, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

**9.2 Exclusive Rights**

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. This Plan is not a guarantee of continuation of any benefits or coverage offered through the Plan.

**9.3 No Property Rights**

No one has any right, title, or interest in the property of the University or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

**9.4 No Assignment of Benefits**

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void.

**9.5 Right to Offset Future Payments**

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

**9.6 Right to Recover Payments**

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

**9.7 Misrepresentation or Fraud**

A Covered Employee who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

**9.8 Legal Action**

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the University and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article V, nor shall an action be brought at all unless within 36 months after the date a claim is incurred under the Plan.

**9.9 Governing Law**

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable and, to the extent not preempted, the laws of the State of New Mexico.

**9.10 Governing Instrument**

This document, together with any documentation incorporated by reference herein, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

**9.11 Savings Clause**

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

**9.12 Captions and Headings**

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

### **9.13 Notices**

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

### **9.14 Waiver**

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

### **9.15 Parties' Reliance**

The Board of Regents, the University, the Employer, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Board of Regents, the University, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

### **9.16 Disclaimer**

The Employer makes no assertion or warranty about:

- A. whether Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or
- B. whether any other tax treatment is or will be applicable.

### **9.17 Expenses**

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

### **9.18 Indemnification**

The University, to the extent permitted by law, shall indemnify and hold harmless the Board of Regents and any employee or officer of the University from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such

person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the University.

## **9.19 Employees' Tax Obligations**

### **A. Excludability Determination**

Covered Employees themselves must determine whether Plan benefits are excludable for tax purposes, and must notify the Plan Administrator if they have reason to believe a payment is not excludable.

### **B. Liability and Payment**

If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan does not qualify as a cafeteria plan under Code section 125 for the Plan Year, then Covered Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions, and
2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess Salary Reduction Contributions or other Employer contributions been treated as taxable income.

**APPENDIX A**  
**NEW MEXICO STATE UNIVERSITY**  
**DEPENDENT CARE SPENDING ACCOUNT PLAN**

**ARTICLE I**  
**PLAN ESTABLISHMENT**

**1.1 Effective Date**

New Mexico State University Dependent Care Spending Account Plan ("the Plan") is **amended** effective January 1, 2015.

**1.2 Purpose**

The Plan is created exclusively for Employees, as defined in Section 2.10 of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Section 2.2, for Dependent Care Expenses, as defined in Section 2.3 of this Plan.

**1.3 Qualification**

The Plan is intended to qualify as a dependent care assistance program under section 129 of the Internal Revenue Code of 1986, as amended (the "Code"). The Plan's reimbursements of Dependent Care Expenses are intended to be eligible for exclusion from Covered Employees' gross income under Code section 129(a). This document is intended to satisfy the written plan document requirement of Code section 129(d)(1).

**1.4 Incorporation by Reference**

The term Cafeteria Plan as used in this Plan means New Mexico State University Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation to the extent such provisions do not conflict with the terms of this Plan.

**1.5 Duration**

The Plan is established with the intention of being maintained for an indefinite period of time; however, the University, as defined in Section 2.5 of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

**ARTICLE II**  
**DEFINITIONS**

When capitalized in this document, these words and phrases have the following meanings:

**2.1 Cafeteria Plan**

Cafeteria Plan means the New Mexico State University Cafeteria Plan.

**2.2 Covered Employee**

Covered Employee means an Employee who satisfies the participation requirements of Article III.

**2.3 Dependent Care Expenses**

Dependent Care Expenses means expenditures for dependent care as described in Section 4.4.

**2.4 Dependent Care Spending Account Plan**

Dependent Care Spending Account means the notational account established on behalf of each Covered Employee who elects the dependent care spending account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Dependent Care Expenses.

**2.5 Effective Date**

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2015. The original effective date of the Plan was January 1, 2008.

**2.6 Exclusions**

Exclusions mean the exclusions in Article V.

**2.7 Maximum Annual Benefit**

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Dependent Care Spending Account, according to the election requirements of Section 6.1, for Dependent Care Expense reimbursement, which amount must be not more than \$5,000 except as otherwise limited under Section 4.5(B).

**2.8 Plan**

Plan means the New Mexico State University Dependent Care Spending Account Plan as herein set forth and as amended from time to time.

## 2.9 Qualifying Individual

Qualifying Individual means:

- A. a Dependent, as defined in Section 2.7 of the Cafeteria Plan who is either:
  - 1. under age 13 and claimable as a personal exemption deduction under Code section 152(a)(1) on the Covered Employee's federal income tax return, or
  - 2. *physically or mentally incapable of caring for him or herself* and is a qualifying relative under Section 152 of the Code (without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) and who resides with the Employee for more than half of the year; or
- B. the spouse of a Covered Employee who is *physically or mentally incapable of caring for himself or herself*, and who resides with the Employee for more than half of the year.

*Physically or mentally incapable of caring for himself or herself* means:

- 1. incapable of caring for one's own hygienic or nutritional needs, or
- 2. requiring another person's full-time attention for one's own safety or the safety of others.

Whether a person is *physically or mentally incapable of caring for him or herself* is determined on a daily basis.



**ARTICLE III**  
**PARTICIPATION**

**3.1 Participation**

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

- A. participates in the Cafeteria Plan, and
- B. has allocated an amount to his or her Dependent Care Spending Account.

Subject to satisfying the procedural requirements of Article VI, Dependent Care expenses incurred during the Plan Year are payable from the Plan, through the end of the Plan Year regardless of when coverage terminates.

**3.2 Termination of Participation**

A Covered Employee shall cease to participate in the Plan when he or she is no longer a participant in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies. Reimbursements from the Dependent Care Spending Account after termination shall be made in accordance with Article XI.

**ARTICLE IV**  
**DEPENDENT CARE REIMBURSEMENT**  
**PREMIUM PAYMENT BENEFIT**

**4.1 Right to Benefit**

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Dependent Care Expenses.

**4.2 Maintenance of Accounts**

The Plan Administrator shall maintain a Dependent Care Spending Account for each Employee who elects the dependent care spending account benefit. The dependent care spending account benefit that the Employee elected under the Cafeteria Plan shall be credited to the Employee's Dependent Care Spending Account on a pro-rata basis over the period for which the Employee's election is effective.

**4.3 Amount Payable**

Subject to the procedural requirements of Article VI, payable Dependent Care Expenses may not exceed the dependent care spending account benefit the Covered Employee authorized and which was credited in accordance with Section 4.3 to his or her Dependent Care Spending Account under the Cafeteria Plan, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

If any balance remains in the a Covered Employee's Dependent Care Spending Account at the end of the Plan Year after all reimbursements have been made, such balance shall not be carried over to reimburse the Covered Employee for Dependent Care Expenses incurred during a subsequent Plan Year nor returned to the Covered Employee and the Covered Employee shall forfeit all rights with respect to such balance. Any amounts forfeited under this Section 4.3 shall not be segregated or invested in an interest bearing account, but shall remain the property of the Employer to be used to pay administrative expenses, to cover expense losses, or used in any other manner as the Employer in its discretion, exercised in a uniform and nondiscriminatory manner, directs.

**4.4 Dependent Care Expenses**

Dependent Care Expenses means *employment-related* expenses that a Covered Employee *incurs* — while employed — for:

- A. *Household services*, and
- B. *Care of a Qualifying Individual*.

*Employment-related*, as defined in Code section 21(b), means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, to be employment-related, the expense must also enable the Covered Employee's Spouse to: be gainfully employed, actively seek gainful employment, or be a *full-time student*, unless the Spouse is described in Section 2.9(B).

*Incurs* refers to the date services resulting in employment-related expenses are provided — not the date charged, billed, or paid.

*Household services* means services ordinarily necessary to maintain a Covered Employee's home and rendered as part of a Qualifying Individual's *care*.

*Care* means services primarily to assure the well-being and protection of at least one Qualifying Individual.

*Full-time student* means a person enrolled at and attending an educational institution during at least part of each of five calendar months of the Covered Employee's tax year for the number of course hours that the institution considers to be a full-time course of study.

#### 4.5 Limits

##### A. On What the Plan Pays

##### 1. For Care Furnished Outside Covered Employee's Household

Dependent Care Expenses for care provided outside a Covered Employee's home or in a *Qualified Dependent Care Center* is reimbursed only if such care is furnished for a Qualifying Individual:

- a. described in Section 2.9(A)(1), or
- b. described in Section 2.9(A)(2) or (B) who regularly spends at least 8 hours each day in the Covered Employee's home.

*Qualified Dependent Care Center* means a facility:

- c. in compliance with all applicable state and local laws and regulations, and
  - d. providing care for more than 6 persons (other than facility residents) on a regular, compensation-for-service basis.
- ##### 2. To Certain "Highly Compensated" Employees

Benefits payable under the Plan to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8).

B. On Exclusion from Gross Income

1. Individual Exclusion Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only to the extent the Dependent Care Expense does not exceed:

- a. the sum of the Covered Employee's actual Salary Reduction Contributions for the Plan Year,  
  
or, if less,
- b. the Maximum Annual Benefit.

2. Gross Income Exclusion Limit

The amount of dependent care expenses reimbursed during a Covered Employee's taxable year by all plans, including the Plan, that qualify as dependent care plans under Code section 129 may not exceed:

- a. \$5,000 (or \$2,500 for a married Covered Employee filing a separate federal income tax return),  
  
or, if less,
- b. the Covered Employee's *earned income* (or if less, the Covered Employee's Spouse's *earned income*, if the Covered Employee was married at the end of his or her tax year).

*Earned income* means wages, salaries, tips, and other compensation, to the extent such amounts are includible in taxable income for the year, like strike benefits, disability pay reported as wages, and net earnings from self-employment.

*Earned income* does not include pensions, annuities, social security payments, workers' compensation, unemployment compensation, or a nonresident alien's income not connected with United States business.

*Earned income* is computed without considering community property laws.

*Earned income* of a Spouse who is a full-time student, as defined in Section 4.4, or who is *physically or mentally incapable of caring for him or herself*, as defined in Section 2.9, is deemed to be not less than \$250 per month for Covered Employees with one Qualifying

Individual or \$500 per month for Covered Employees with two or more Qualifying Individuals.

3. Reporting Identifying Information Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only if the Covered Employee reports on the federal income tax return to which the exclusion relates, the name, address, and taxpayer identification number (or other information acceptable to comply with federal reporting requirements) of each dependent care service provider furnishing dependent care services to the Covered Employee during the year.

**ARTICLE V**  
**EXCLUSIONS**

**5.1 General Rules**

- A. The Plan pays only those Dependent Care Expenses incurred by an Employee:
1. during the current Plan Year
  2. while the Employee is a Covered Employee, and
  3. to allow the Covered Employee (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Covered Employee's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.4, unless the Spouse is described in Section 2.9(B), of the Plan).
- B. Except as provided in Section 5.1(A)(3), the Plan does not reimburse amounts paid for Dependent Care Expenses incurred while a Covered Employee (or Spouse, if married) is off work for any reason, including illness or vacation. However, if Dependent Care Expenses are paid to the dependent care services provider on a weekly or longer basis, Dependent Care Expenses incurred during a temporary absence from work for illness or vacation will not be subject to this exclusion.

**5.2 Specific Exclusions**

The Plan does not reimburse amounts paid in connection with:

- A. a Qualifying Individual's overnight camp;
- B. services rendered by:
1. a Covered Employee's (and if married, the Covered Employee's Spouse's) child (within the meaning of Code section 152(c)(3)) under age 19 at the Plan Year's end,
  2. a Covered Employee's Spouse or parent of the Covered Employee's child, or
  3. a person for whom the Covered Employee (or if married, the Covered Employee's Spouse) is entitled to a federal income tax deduction under Code section 151(c) for the Covered Employee's tax year.

### **5.3 Conditional Exclusions**

Unless incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, the Plan shall not pay any charges in connection with a Qualifying Individual's:

- A. food,
- B. clothing,
- C. entertainment, or
- D. education (kindergarten and above).
- E. transportation between the Covered Employee's home and the place where dependent care is provided unless such transportation is furnished by the dependent care provider.

**ARTICLE VI**  
**PROCEDURES**

**6.1 Enrollment and Election Procedures**

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

**6.2 Claim Procedures**

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator no later than three months after the end of the Plan Year (or, if applicable, the date of termination within the Plan Year) to which the claim relates.

**6.3 Claim Administrator**

The Plan Administrator and/or the University shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

**6.4 Claims Administration**

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

**6.5 Proof of Claim**

As a condition of receiving Plan benefits, claimants must:

- A. submit to the Claim Administrator:
  - 1. a properly completed and timely filed claim form,
  - 2. a written declaration stating the dependent care expense has not been reimbursed and is not reimbursable under any other dependent care plan, and
  - 3. a written declaration from an independent third party stating the Covered Employee has incurred the dependent care expense and the amount of such expense; and



B. prove any claimed status.

**APPENDIX B**  
**NEW MEXICO STATE UNIVERSITY**  
**HEALTH CARE SPENDING ACCOUNT PLAN**

**ARTICLE I**  
**PLAN ESTABLISHMENT**

**1.1 Effective Date**

The New Mexico State University Health Care Spending Account Plan ("the Plan") is **amended** effective January 1, 2015.

**1.2 Purpose**

The Plan is created exclusively for Employees, as defined in Section 2.10 of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Section 2.2, for Qualifying Medical Expenses, as defined in Section 2.9 of this Plan.

**1.3 Qualification under the Internal Revenue Code**

The Plan is intended to qualify as a health plan under section 105(e) of the Internal Revenue Code of 1986, as amended ("the Code"). The Plan's Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees' gross income under Code section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations section 1.105-11(b)(1)(i).

**1.4 Incorporation by Reference**

The term Cafeteria Plan as used in this Plan means the New Mexico State University Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

**1.5 Duration**

The Plan is established with the intention of being maintained for an indefinite period of time; however, University, as defined in Section 2.5 of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

**ARTICLE II**  
**DEFINITIONS**

When capitalized in this document, these words and phrases have the following meanings:

**2.1 Cafeteria Plan**

Cafeteria Plan means the New Mexico State University Cafeteria Plan.

**2.2 Covered Employee**

Covered Employee means an Employee who satisfies the participation requirements of Article III.

**2.3 Dependent**

Dependent means a Covered Employee's:

- A. Spouse, and
- B. dependent(s) as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)), and
- C. the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

**2.4 Effective Date**

Effective Date means the date the amended and restated Plan becomes operative; the Effective Date is January 1, 2015. The original effective date of the Plan was August 1, 2003.

**2.5 Exclusions**

Exclusions mean the exclusions in Article V.

**2.6 Health Care Spending Account**

Health Care Spending Account means the notational account established on behalf of each Covered Employee who elects the Health Care Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

**2.7 Maximum Annual Benefit**

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care Spending Account, according to the election

procedures of Section 7.1, for Qualifying Medical Expense reimbursement, which amount must be not more than \$2,500, or if less, the maximum amount allowed under Section 125 of the Code, in addition to any amount the Covered Employee may elect to carry over from the previous Plan Year, provided that they are a Covered Employee as of the last day of the Plan Year, up to \$500 or the amount of the account balance at the end of the previous Plan Year, whichever is less.

## **2.8 Plan**

Plan means the New Mexico State University Health Care Spending Account Plan as herein set forth and as amended from time to time.

## **2.9 Qualifying Medical Expenses**

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses *incurred* during the Plan Year for medical care, as defined in Code section 213(d)(1)(A) and (B). To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. *Incurred* refers to the date the medical care is provided — not to the date charged, billed, or paid.

**ARTICLE III**  
**PARTICIPATION**

**3.1 Participation**

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

- A. participates in the Cafeteria Plan, and
- B. has allocated an amount to his or her Health Care Spending Account.

Except for Qualifying Medical Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VII, no Plan benefits are payable after coverage terminates.

**3.2 Termination of Participation**

A Covered Employee shall cease to participate in the Plan when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

Notwithstanding Section 3.1, a Covered Employee ordered or called to active military duty (by reason of being a member of a reserve component as defined in section 101 of title 37, United States Code) for a period in excess of 179 days, or for an indefinite period of time, may elect to take his or her unused Health Care Spending Account balance as a cash distribution by the last day of the Plan Year. Such distribution shall be subject to income tax and the Covered Employee shall cease to participate in the Plan for the remainder of the Plan Year. Such distribution shall be calculated as the amount actually contributed for the Plan Year to date minus any reimbursements.

## ARTICLE IV

### MEDICAL EXPENSE REIMBURSEMENT BENEFIT

#### 4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

#### 4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Health Care Spending Account for each Employee who elects the health care spending account premium payment benefit. The health care spending account premium payment benefit elected by the Employee shall be credited to his or her Health Care Spending Account as of the first day that the Employee's election is effective.

#### 4.3 Amount Payable

Subject to the procedural requirements of Article VII, payable Qualifying Medical Expenses may not exceed the health care spending account premium payment benefit the Covered Employee elected to be credited to his or her Health Care Spending Account for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit, plus any amounts carried over from prior Plan Years pursuant to Section 4.3 of the New Mexico State University Cafeteria Plan.

#### 4.4 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined in Section 2.9 that are not covered by any other health plan as defined under Code §213(d) and related guidance, including, but not limited to, IRS Publication 502, except where IRS Publication 502 conflicts with Code §213(d), in which case Code §213(d) will control. For example, prescribed over-the-counter medicine and drugs are reimbursable and insurance premiums are not reimbursable as Qualifying Medical Expenses.

#### 4.5 Limits

The Plan reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

**ARTICLE V**  
**EXCLUSIONS**

**5.1 General Rules**

- A. The Plan pays only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:
  - 1. during the current Plan Year except as permitted under Section 4.3 of the New Mexico State University Cafeteria Plan for amounts carried over into a subsequent Plan Year, and
  - 2. while the Employee is a Covered Employee.
- B. The Plan does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

**5.2 Specific Exclusions**

The Plan does not reimburse amounts paid in connection with:

- A. cosmetic surgery or similar procedure unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- B. custodial or domiciliary care
- C. diaper service
- D. funeral and burial expenses
- E. health club membership fees and dues
- F. household and domestic help
- G. illegal services and supplies
- H. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance
- I. meals and lodging at a non-medical facility
- J. maternity clothes or uniform

- K. nursing services for a normal, healthy newborn baby, except for breast pumps and supplies that assist lactation,
- L. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation
- M. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification
- N. schooling or tuition for scholastic improvement or discipline
- O. social activities like dancing or swimming lessons
- P. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods
- Q. transportation for non-medical reasons,
- R. trips or vacations
- S. long term care expenses



## ARTICLE VI

### COBRA CONTINUATION COVERAGE

#### 6.1 Eligibility for Continuation Coverage

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

#### 6.2 Definitions

For purposes of this Article VI, the following terms have the following meanings:

- A. “Employee” means a person who is (or was) covered under the Plan by virtue of the person’s performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.
- B. “Dependent” means, with respect to an Employee as defined in this Section 6.2, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Dependent Spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.
- C. “Qualified Beneficiary” means an Employee or Dependent as defined in this Section 6.2 but shall not mean Dependents defined in Section 6.7(B), except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.
- D. “Qualifying Event” means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:
  - 1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;
  - 2. for Dependents:
    - a. death of the Employee;
    - b. divorce of the Employee and Spouse;

- c. legal separation of the Employee and Spouse;
- d. reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct;
- e. entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare); or
- f. ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

### **6.3 Loss of Eligibility for Continuation Coverage**

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

- A. The University or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:
  - 1. The date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in Section 6.2(D); or
  - 2. The date notice of eligibility is sent to the individual in accordance with Section 6.5(C); and
- B. The Qualified Beneficiary pays the initial required premium, as set forth in Section 6.8, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

### **6.4 Termination of COBRA Continuation Coverage**

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

- A. The last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;
- B. The date the Qualified Beneficiary first becomes, after the date of election, entitled to Medicare;

- C. The date the Qualified Beneficiary first becomes, after the date of election, covered under another group health plan, as defined in Code section 5000(b)(1), not containing a limitation or exclusion as to any pre-existing condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996);
- D. The last day of the Plan Year in which the Qualifying Event occurs; or
- E. The date the University terminates all group health plans.

## **6.5 Notice Requirements**

Notice requirements shall be as follows:

- A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Section 6.2(D)(1), 6.2(D)(2)(a), 6.2(D)(2)(d), and 6.2(D)(2)(e) within 30 days of the date of the described event;
- B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 6.2(D)(2)(b), 6.2(D)(2)(c), or 6.2(D)(2)(f) within 60 days of the date of the described event.
- C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 6.5(A) and (B).
- D. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or Dependent spouse who is a Covered Person with notice of their rights under COBRA.
- E. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.
- F. The Plan Administrator shall provide notice to each Employee, Spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, Spouse or Dependent is not entitled to COBRA continuation coverage.

## **6.6 Coverage Available for Continuation**

A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health Care Spending Account immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event. To the extent that a Qualified

Beneficiary is only eligible for a limited COBRA election for his or her Health Care Spending Account (pursuant to Treas. Reg. §54.4980B-2, Q/A-8(e)), the carryover described in Section 4.3 of the New Mexico State University Cafeteria Plan will not apply to his or her account at the end of the Plan Year, unless IRS guidance otherwise requires.

## **6.7 Election Rules**

### **A. Scope of Election**

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Article VI; provided, however, that in the event an Employee or his or her Spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

### **B. After Acquired Dependents**

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents as defined in Section 6.2(B) acquired after the date of eligibility described under Section 6.1 to the same extent as Covered Employees, provided the University or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 6.2(C), shall have no independent right to COBRA continuation coverage. Failure to notify the University or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

## **6.8 Required Premium**

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

## **6.9 Forfeiture of Unused Reimbursement Amount**

If at the termination of COBRA continuation coverage, the expenses submitted for reimbursement are less than the level of reimbursement in effect under this Article, the amount of such excess shall be forfeited and the Qualified Beneficiary shall have no further entitlement under the Plan and no entitlement to any such forfeited amount.

## **ARTICLE VII**

### **PROCEDURES**

#### **7.1 Enrollment and Election Procedures**

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

#### **7.2 Claim Procedures**

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator no later than three months following the Plan Year (or, if applicable, the date of termination within the Plan Year) to which the claim relates.

#### **7.3 Claim Administrator**

The Plan Administrator and/or the University shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

#### **7.4 Claims Administration**

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

#### **7.5 Claimants**

A Covered Employee (or his or her duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled.

## **7.6 Claim Forms**

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

## **7.7 Deadline for Filing a Claim**

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claim Administrator no later than three months following the Plan Year (or, if applicable, the date of termination within the Plan Year) to which the claim relates. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

## **7.8 Proof of Claim**

As a condition of receiving Plan benefits, claimants must:

- A. submit to the Plan Administrator:
  - 1. a properly completed and timely filed claim form,
  - 2. a written declaration stating the Qualifying Medical Expense has not been reimbursed and is not reimbursable under any other health plan, and
  - 3. a written declaration from an independent third party stating the Covered Employee has incurred the medical expense and the amount of such expense; and
- B. prove any claimed status.

## **7.9 Decision on the Claim**

The Plan has up to 30 days, to evaluate and process claims for benefits. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

- 1. Notification of Denial

An “adverse benefit determination” is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim denial on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. In the event of an adverse benefit determination, the claimant will receive notice of the determination.

If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information:

- a. the specific reason(s) for the denial;
- b. a reference to the specific provision(s) in the Plan on which the denial is based;
- c. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;
- d. a description of the Plan’s claim and appeal procedures and applicable timeframes;
- e. a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA, if applicable, after the Plan’s appeal procedure (set forth below) has been exhausted;
- f. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- g. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

## **7.10 Right to Appeal**

A claimant who has had a claim benefits wholly or partially denied by the Claim Administrator or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator’s action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of

the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than sixty (60) days after receipt of the request for review (or 30 days following each appeal if there are two mandatory appeals).

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

- a. the specific reason(s) for the denial;
- b. a reference to the specific provision(s) in the Plan on which the denial is based;
- c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;
- d. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA, if applicable;
- e. a description of any voluntary appeals procedures offered by the Plan, if any;
- f. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;
- g. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- h. for denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making the determination.



In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Claim Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

#### **7.11 Legal Remedy**

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

#### **7.12 Payment Procedures**

##### **A. Payment of Claim**

Subject to Section 9.4 of the Cafeteria Plan, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Claim Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Claim Administrator deems appropriate.

##### **B. Facility of Payment**

If a claimant dies before all amounts payable under the Plan have been paid, or if the Claim Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Claim Administrator to be entitled equitably thereto and without prejudice therefore. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

C. Forfeiture

The Claim Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Claim Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

**7.13 Proof of Claim**

As a condition of receiving Plan benefits, claimants must:

- A. submit to the Claim Administrator:
  - 1. a properly completed and timely filed claim form,
  - 2. a written declaration stating the Qualifying Medical Expense has not been reimbursed and is not reimbursable under any other health plan, and
  - 3. a written declaration from an independent third party stating the Covered Employee has incurred the medical expense and the amount of such expense; and
- B. prove any claimed status.

## ARTICLE VIII

### HIPAA PRIVACY AND SECURITY

#### 8.1 Definitions

For purposes of this Article VIII, the following terms have the following meanings:

- A. “Business Associate” means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. Effective February 17, 2010, a person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates. Vendors that contract with Business Associates (“subcontractors”) and require or have access to PHI or ePHI on a routine basis may also be Business Associates with respect to the Plan.
- B. “Covered Entity” means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).
- C. “Protected Health Information or PHI” means individually identifiable health information created or received by a Covered Entity. Information is “individually identifiable” if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. “Health Information” means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

## **8.2 Uses and Disclosures of PHI**

The Plan and the Employer may disclose a Covered Employee's PHI or ePHI to the Employer (or to the agent of the Employer) for the plan administration functions under 45 CFR §164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Employer except upon receipt of a certification by the Employer that the Plan incorporates the agreements of Sections 8.3 and 8.4, except as otherwise permitted or required by law.

## **8.3 Privacy Agreements of the Employer**

As a condition for obtaining PHI from the Plan and its Business Associates the Employer agrees it will:

- A. Not use or further disclose such PHI other than as permitted by Section 8.2, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;
- B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- D. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;
- E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;
- F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Employer pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;
- G. Make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- H. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- I. Ensure that there is adequate separation between the Plan and the Employer by implementing the terms of subparagraphs (1) through (3), below:
  1. Employees With Access to PHI: The employees, classes of former employees or other individuals under the control of the Employer listed on Schedule A are the only individuals that may access PHI or ePHI received from the Plan.
  2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Plan.
  3. Mechanism for Resolving Noncompliance: If the Employer or the persons listed on Schedule A determine that any person described in (1), above, has violated any of the restrictions of this Article VIII, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy and security compliance, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.
  
- J. Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a “Breach”) without unreasonable delay in a report which includes the following information:
  1. the names of the individuals whose PHI was involved in the Breach;
  2. the circumstances surrounding the Breach;
  3. the date of the Breach and the date of its discovery;
  4. the information Breached;
  5. any steps the impacted individuals should take to protect themselves;
  6. the steps the University is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and
  7. a contact person who can provide additional information about the Breach.

The University will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term “Breach” means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

Notwithstanding the foregoing, the terms of this Article VIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

#### **8.4 Security Agreements of the Employer**

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the Employer agrees it will:

- A. 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 Plan;
- B. Ensure that the adequate separation between the Plan and the Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- D. Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and
- E. Upon request from the Plan, the Employer agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Employer.

**SCHEDULE A**

**Individuals with Access to PHI**

Benefit Services Department

Business Operations Department