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MORAVIAN COLLEGE FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

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MORAVIAN COLLEGE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Moravian College maintains Moravian College Flexible Benefits Plan for the benefit of its eligible employees. The terms of the Plan are contained in a lengthy, legally worded document. This Summary Plan Description is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name and Number:

   Moravian College Flexible Benefits Plan; no. 501

2. Employer, Address and Identification Number:

   Moravian College
   1200 Main Street
   Bethlehem, PA 18018
   24-0795460

3. Plan Administrator and Agent for Service for Process:

   Moravian College
   1200 Main Street
   Bethlehem, PA 18018
   610 861-1528

4. Claims Administrator:

   The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

   You may submit your claims online at P&A's website, www.padmin.com, by logging into your P&A Account or by using your smartphone.

   Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 716 855-7105.

5. Plan Year-End:

   December 31

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THE FLEXIBLE BENEFITS PLAN OVERVIEW

The Plan gives you the opportunity to avoid taxes on the part of your pay that you spend on certain expenses: health care expenses that are not covered by insurance; and expenses for the care of your children or other dependents so that you are able to work. So that you and other eligible employees can enjoy the tax savings the Plan is intended to provide, the Plan is operated according to certain rules contained in the federal tax laws and regulations.

If you want to take advantage of the tax savings potential that the Plan offers, you will need to figure out the types and amounts of covered expenses that you will have each year. Then, you will need to complete an election form based on your determination. When you complete an election form, you will indicate the benefits that you want, and you will instruct the Employer to withhold from your pay any money needed to cover the cost of those benefits.

The following is a list of some of the more commonly asked questions regarding your Plan.

PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

This Summary reflects the terms of the Plan as of January 1, 2021.

WHAT IS THE PLAN YEAR?

"Plan Year" refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on January 1 and ending on the following December 31.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

To be eligible for the Plan, you must be regularly scheduled to work at least 30 hours a week for the Employer. You qualify to elect benefits under the Plan by becoming a Plan "Participant" on the first day of the month after you start working for the Employer as an eligible employee.

Even after you have become a Participant, if your Employer contributes to a Health Savings Account ("HSA") for you for a particular Plan Year (or if you make your own contributions), you may not have a Medical Expense Reimbursement Account under this Plan for that Plan Year.

HOW DO I PARTICIPATE?

When you become a Participant, you will receive a form that you can use to elect the benefits that you desire.

PLAN CONTRIBUTIONS

HOW ARE BENEFITS PAID FOR?

You pay for your own benefits under the Plan with amounts withheld from your pay based on your election form. These pay reductions do not count as income for income tax or Social Security tax purposes (exceptions: *If you are a New Jersey taxpayer, the New Jersey state income tax will apply to any salary reductions that you elect and, if you are a Pennsylvania taxpayer, the Pennsylvania state income tax will apply to any salary reductions that you elect to pay for benefits under the Dependent Care Assistance Account Option*). This means that the Plan allows you to use tax-free dollars to pay for expenses that would otherwise have to be paid with funds included in your taxable income.

WHEN ARE CONTRIBUTIONS MADE TO THE PLAN?

Unless the Employer tells you otherwise, the cost of your benefits will be withheld each pay period on a pro rata basis over the course of the Plan Year.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED BY MY CONTRIBUTIONS TO THE PLAN?

Your Social Security benefits may be slightly reduced because, when your pay is reduced to cover your benefits under the Plan, the amount of contributions that are made to the federal Social Security system to provide you Social Security benefits also are reduced.

PLAN BENEFITS

WHAT BENEFITS MAY I CHOOSE UNDER THIS PLAN?

Flexible Spending Account Options

The benefits that may be elected in lieu of cash compensation consist of certain types of expenses that you may elect to pay with funds that are not subject to taxation. If you want to pay for your uninsured health care expenses through the Plan, elect the Medical Expense Reimbursement Account Option described below; and if you want to pay for day care costs through the Plan, elect the Dependent Care Assistance Account Option described below.

If you elect benefits under the Medical Expense Reimbursement Account Option or the Dependent Care Assistance Account Option (together called the “Flexible Spending Account Options”), your contributions to pay for your expenses covered by that option will be credited to an account in your name. This “Account” is for record-keeping purposes only and does not involve any actual segregation of funds.

HSA Contribution Option

In addition, you may elect to reduce your salary by a specified amount and to have that amount contributed to a Health Savings Account. Any election to contribute to an HSA may be changed monthly.

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WHAT BENEFITS ARE AVAILABLE UNDER THE MEDICAL EXPENSE REIMBURSEMENT ACCOUNT OPTION?

If you elect the Medical Expense Reimbursement Account Option, you will be reimbursed for the cost of medical care for yourself, your Spouse or Dependents that is not covered under any other plan or policy. "Medical care" involves the diagnosis, cure, treatment or prevention of disease. Expenses for medical care include expenses for routine and extraordinary medical and dental examinations, vision exams and eye-wear, surgery, psychiatric care, hospitalization, insulin, drugs and medicines obtained by prescription, therapeutic, orthopedic and prosthetic aids and devices, and transportation primarily for essential medical care.

The largest amount of benefits that you may elect under this Option is the maximum amount permitted by the Internal Revenue Code at the time of your election. The smallest amount that you may elect is $24.

An amount that normally would apply will be prorated if you are making an election covering fewer than 12 months.

WHAT BENEFITS ARE AVAILABLE UNDER THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION?

If you select the Dependent Care Assistance Account Option, you will be reimbursed for your qualified dependent care expenses. Only expenses that meet all the following conditions qualify for reimbursement:

1. The expenses were incurred for services rendered after the date you became a Participant.

2. Each individual for whom you incur the expense:

   (a) Is either (i) a Dependent under age 13 whom you are entitled to claim as a Dependent on your federal income tax return or (ii) a Spouse or other Dependent for tax purposes who is physically or mentally incapable of caring for himself or herself, and

   (b) Lived with you for most of the calendar year.

3. The expenses are incurred for the care of a Dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services provided by a Dependent care center (*i.e.,* a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

5. The expenses are not for services provided by a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not for services provided by an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

Eligible expenses include the cost of babysitters, daycare centers, nursery schools, after-school programs, eldercare and day camps. The cost of overnight camp is not an eligible expense.

WHAT EFFECT WILL PARTICIPATION IN THE DEPENDENT CARE ASSISTANCE ACCOUNT OPTION HAVE ON MY RIGHT TO THE DEPENDENT CARE CREDIT ON MY TAX RETURN?

The amount of your expenses that are eligible for the federal dependent care credit must be reduced, dollar for dollar, by the amount of expenses that you pay through the Dependent Care Assistance Account Option under this Plan. Before choosing that benefit option, you should determine if you would save more money by choosing instead to use the full, unreduced tax credit amount.

ARE THERE ANY LIMITS ON THE AMOUNT THAT MAY BE EXCLUDED FROM MY PAY FOR DEPENDENT CARE ASSISTANCE?

Yes. In general, the amount of expenses that you may pay through the Dependent Care Assistance Option is limited to $5,000 per *calendar* year ($2,500 if you are married but you and your Spouse file separate tax returns). However, the amount of expenses can never exceed your earnings for the year or the earnings of your Spouse, whichever is lower. Special rules apply in determining the earnings of a Spouse who is a student or incapable of caring for himself or herself.

WHO IS CONSIDERED A SPOUSE? A DEPENDENT?

Only insurance coverage for a Participant, a Participant's Spouse or a Participant's Dependent may be paid with funds that are not subject to taxation, and only the medical expenses of a Participant, a Participant's Spouse or a Participant's Dependent may be reimbursed with funds that are not subject to taxation.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state.

Relatives as Dependents

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 26, it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement under the Medical Expense Reimbursement Account Option of the health expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of the benefits that may be elected under the Medical Expense Reimbursement Account Option, "Dependent" also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the Summary.

Non-Relatives as Dependents

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To qualify as a Dependent, a person who is not related to a Participant must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;

2. have the same principal residence as the Participant for the entire calendar year; and

3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

FLEXIBLE SPENDING ACCOUNT CLAIMS

HOW DO I RECEIVE FLEXIBLE SPENDING ACCOUNT BENEFITS?

There are two ways to receive payment of your Flexible Spending Account expenses under the Plan.

Electronic Payment Method

If you elect benefits under the Medical Expense Reimbursement Account Option or the Dependent Care Assistance Account Option, the Administrator will issue a debit card for you to use. Then, as you have eligible expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office, a pharmacy or a day care center). If the provider accepts the card, the provider will swipe the card in a manner similar to the way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Plan's Claims Administrator.

These rules apply to your use of the debit card:

1. When you use the card to obtain benefits, you will be certifying to the Plan that you are using it only for payment of eligible expenses.

2. You are not excused from the legal requirement that every benefit payment by the Plan must be supported by information that shows who provided you with the eligible product or service, the date you received the product or service and the amount you paid for the product or service. If the information that the Claims Administrator receives electronically about an expense when you swipe the card to pay for that expense is not sufficient, then you will be required to provide the missing information.

3. You will not be required to provide any follow-up information for certain expenses that you have paid for using the card. These are: (a) expenses that match exactly a co-payment amount under your health insurance; (b) repeating expenses that have already been approved by the Plan such as prescription drug refills; and (c) expenses where the information that the Claims Administrator receives electronically when you swipe the card is detailed enough to adequately justify the payment without any further information from you.

4. If you are required to provide additional support for an expense and fail to do so or if the Claims Administrator determines that an expense was ineligible for payment, you will be required to

immediately repay the Plan. If you do not repay the Plan, the Employer will withhold the amount involved from your paycheck and, if necessary, the Plan will reduce your right to the payment of future claims. Also, you will lose the right to use the card.

5. You will lose the right to use the card immediately if you become ineligible for the Plan, even though you may have the right to submit further claims after you lose eligibility.

Claim Form Submission Method

You can also obtain reimbursement for expenses allowed under the Flexible Spending Account Options by submitting reimbursement claim forms and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expense. It is your responsibility to maintain adequate records to verify these expenses. The Claims Administrator will determine the extent to which the expenses are covered and will pay any benefits due you under the Plan.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

WHAT IS THE MAXIMUM AMOUNT I CAN RECEIVE WHEN I SUBMIT A CLAIM?

Medical Expense Reimbursement Claims

If, for any Plan Year, you make an election under the Medical Expense Reimbursement Account Option, the amount that you elect will be immediately credited to a Medical Expense Reimbursement Account in your name. Starting on the first day of that Plan Year, you will be entitled to be reimbursed for claims up to the entire elected amount (reduced by the amount of reimbursement that you've already received from your Account during that Plan Year) at any time during the Plan Year, even if the total salary reduction contributions that you have made to your Medical Expense Reimbursement Account are less that the total amount of claims that you have submitted.

Dependent Care Claims

The largest amount available to pay a claim that you submit under the Dependent Care Assistance Account Option is the amount credited to your Dependent Care Assistance Account at the time your claim is received.

Carryover of Unused Medical Expense Reimbursement Account Balance

A special Plan provision may benefit you if you have a Medical Expense Reimbursement Account election in effect on the last day of a Plan Year and you remain actively employed by the Employer on that date.

As soon as the Plan Year has ended, the Claims Administrator will determine whether you have any money left in your Account to reimburse your expenses. If you do, the remaining money (up to $500) will be carried over to a Medical Expense Reimbursement Account on the first day of the new Plan Year.

The carried over money will continue to be available to reimburse your medical expenses in the prior Plan Year until the end of the Plan's claims run-out period for that Plan Year. It will also be available to reimburse your medical expenses in the new Plan Year once you've used up all the money credited to your Account from your benefits election for the new Plan Year (if you make such an election). However, if carried over money is used to reimburse expenses from the prior Plan Year that will reduce the amount available to pay your prior year

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expenses during the claims run-out period for that Plan Year.

You May Decline a Carryover

You may not have a Medical Expense Reimbursement Account and make HSA contributions at the same time. If you want to be eligible to make HSA contributions during a particular Plan Year, you may waive your right to receive a Medical Expense Reimbursement Account carryover for that Plan Year before it begins.

WHAT IS THE DEADLINE FOR SUBMITTING CLAIMS?

The deadline for submitting Flexible Spending Account claims is March 31st of the following Plan Year.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

You will be notified in writing by the Claims Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claims Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. The reason or reasons that your claim was denied;

2. The specific Plan provision on which the denial was based;

3. A description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and

4. Information on the steps that you must take to appeal the Claims Administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request and at no charge, relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appealing a Claim Denial

If the Claims Administrator denies your claim or any part of your claim, you or an authorized

representative of yours may apply to the Claims Administrator's Manager of Flex & Claims Administration for the Plan to review the denial. Your appeal must be made in writing within 180 days after you received notification from the Claims Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

Decision on Review

The Claims Administrator's Manager of Flex & Claims Administration will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Manager of Flex & Claims Administration may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. The specific reasons for the decision on review;

2. The specific Plan provision or provisions on which the decision is based;

3. A statement of your right to review, upon request and at no charge, relevant documents and other information;

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

5. A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

WHAT HAPPENS TO MONEY LEFT IN MY FLEXIBLE SPENDING ACCOUNT?

Except for a Medical Expense Reimbursement Account carryover amount (described above), any amount that remains credited to a Flexible Spending Account at the end of the permissible reimbursement period for a Plan Year will be forfeited and used to offset the Plan's administrative expenses and future costs. Because your salary reduction contributions not used to reimburse you for expenses incurred in the Plan Year will be forfeited, it is important that you carefully determine the proper amount of your compensation to allocate to each account.

MID-YEAR CHANGES

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

If you take a leave of absence from your employment with the Employer, your election for benefits under

the Plan will remain in effect if your compensation from the Employer will continue to be paid during that leave. If, on the other hand, your leave is unpaid, you will have the opportunity, before the leave starts, to revoke your election and, if desired, make a new election in accordance with the rules discussed below at the Section entitled, "May I Change My Benefit Election?"

If you take a leave of absence to which the Family Medical Leave Act of 1993 ("FMLA") applies, during the period of such leave you will have the option of continuing your coverage under the Employer's medical insurance plan and Medical Expense Reimbursement Account Option on the same terms and conditions as though you were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent you elect to continue your coverage). You may do so by either paying your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or by prepaying all or a portion of your share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreeable to the Administrator. Upon return from FMLA leave, you will be permitted to reenter the Plan on the same basis on which you were participating prior to taking leave.

MAY I CHANGE MY BENEFIT ELECTION?

While you may change your election before the beginning of a new Plan Year, as a rule, you may not change an election of benefits during the Plan Year. However, if you experience any of the following events, you may revoke your election after the Plan Year has commenced and make a new election for the balance of the Plan Year:

1. *Change in Status*.

(a) A change in your legal status (e.g., marriage, death of your Spouse, divorce, legal separation or annulment).

(b) A change in the number of your dependents due to events such as birth, adoption, placement for adoption or death.

(c) A termination or commencement of employment by your Spouse or Dependent.

(d) A reduction or increase in the hours that you, your Spouse or your dependents work, including a switch between part-time and full-time status and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan that you, your Spouse or your Dependent depend on the employment status of the individual and a change in that individual's employment status causes that individual either to become eligible or cease to be eligible under the plan, that change constitutes a Change in Status.

(e) An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for a certain benefit (e.g., due to attainment of a certain age).

(f) A change in the place where you, your Spouse or your Dependent work or reside.

If you wish to change your election based on a Change in Status, the change must be consistent

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with that Change in Status, under the following rules:

Your change of election will be considered to be consistent with a Change in Status only if the Change in Status results in you, your Spouse or your Dependent gaining or losing eligibility for a benefit (or particular benefit option) under a plan of the Employer or under a plan of your Spouse's or Dependent's employer, and the change of election corresponds with that gain or loss of coverage, or, if the Change in Status affects dependent care expenses.

If the Change of Status is your divorce, annulment or legal separation, the death of your Spouse or Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, you may not make an election under the Plan to cancel accident or health coverage for any individual other than your Spouse involved in the divorce, annulment or legal separation, your deceased Spouse or Dependent or the Dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, since such an election would not correspond with that Change in Status. In addition, if you or your Spouse or Dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are nontaxable benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes available or is increased under the plan from which eligibility for coverage has been gained.

If you, your Spouse, or your Dependent become eligible for COBRA coverage, you may elect to increase payments under this Plan to pay for that coverage.

2. *Special Enrollment Rights*. If you become eligible to exercise any HIPAA special enrollment rights regarding group health plan coverage, you may change your election for the balance of the Plan Year and file a new election that corresponds with your exercise of those rights.

3. *Certain Judgments and Orders*. If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires that your child, or a foster child who is your Dependent, be covered under the Employer's health plan or the health plan of your former Spouse's employer, you may change your election to provide coverage for the child under the Employer's plan if the order requires it or change your election to cancel coverage for the child under the Employer's plan if the order requires your Spouse or former Spouse, or any other individual, to provide the coverage.

4. *Entitlement to Medicare or Medicaid*. If you, your Spouse, or your Dependent becomes entitled to coverage under Medicare or Medicaid, you may cancel that person's coverage under the Employer's health plan. In addition, if you, your Spouse, or your Dependent loses eligibility for Medicare or Medicaid coverage, you may make an election to commence or to increase that person's coverage under the Employer's health plan.

5. *Change in Cost or Coverage.* A change of cost or change of coverage with respect to non-cash benefits that may be elected under this Plan may be the basis for a change of election based on the following rules:

(a) These rules do not apply to benefits under the Medical Expense Reimbursement Account Option.

(b) If the cost of any of your benefits increases or decreases during a period of coverage and, as a result, you are required to increase or decrease your payments for those benefits, your salary reductions contributions under this Plan will be adjusted accordingly, unless you make a change to your election under (c) below.

(c) If the cost of any of your benefits significantly increases during a period of coverage, you may elect either to increase your contributions to pay for the increased cost or to revoke your election and to receive instead coverage under another benefit option of the plan providing the benefits. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which you have not elected that benefit or benefit option, you may make a new election of that type of benefit or benefit option. If you have an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect the benefit option that has significantly decreased in cost.

(d) You may only change your election due to an increase in the cost of dependent care assistance benefits if your Dependent care provider is not your relative.

(e) If your coverage under any benefit plan is significantly reduced or stops, you may make a new election going forward of any other coverage option available under that plan. Coverage under an accident or health plan is considered to be reduced only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(f) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your Spouse, former Spouse or Dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules or if that plan permits participants to make an election for a period of coverage under the cafeteria plan or other plan that is different than that under this Plan.

6. *Changes in Coverage Attributable to Spouse's Employment*. You may revoke a prior election and make a new election where there has been a significant change in benefit plan coverage for you, your Spouse or your Dependent related to your employment or the employment of your Spouse or Dependent, if that change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

The Administrator must be notified within 30 days of any such event or circumstance to make an election change, except if you become eligible for HIPAA special enrollment rights that may be exercised within 60 days after you become eligible, in which case the Plan Administrator must be notified of your election change within 60 days after you become eligible.

Even if you are permitted to change your election under these rules, you may not change your election for Flexible Spending Account benefits below the amount of such benefits already reimbursed for the Plan Year.

If you fail to submit a new election form for any new Plan Year, you will be considered not to have elected any Flexible Spending Account benefits for the new Plan Year.

MAY MY ELECTION BE CHANGED WITHOUT MY CONSENT?

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If the Plan Administrator determined before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any elections with or without the consent of the Employee.

WHAT HAPPENS IF I STOP WORKING FOR THE EMPLOYER OR I BECOME INELIGIBLE FOR THE PLAN FOR ANOTHER REASON?

You will lose eligibility for the Plan if you stop working for the Employer as an eligible type of employee. When you lose eligibility for the Plan:

1. Your contributions for benefits will cease.

2. If you still had money credited to a Medical Expense Reimbursement Account when you lost eligibility, the remaining Account balance may be used to reimburse you for eligible expenses you had before you lost eligibility.

3. If you still had money credited to a Dependent Care Assistance Account of any other type when you lost eligibility, the remaining Account balance may be used to reimburse you for eligible expenses you had during the entire Plan Year (even if after you lost eligibility).

4. Your remaining claims must be submitted by March 31st of the following Plan Year.

COBRA COVERAGE

ARE THERE ANY CIRCUMSTANCES UNDER WHICH I MAY CONTINUE TO RECEIVE COVERAGE AFTER MY EMPLOYMENT TERMINATES?

COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under a group health plan. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you and to other members of your family who are covered under a plan when you would otherwise lose coverage.

The COBRA law generally applies to all "group health plans' maintained by an employer. However, the purpose of this section of the Summary is limited to **explaining the COBRA rules that could allow you to continue your Medical Expense Reimbursement Account after you lose eligibility for the Plan.**

COBRA Coverage

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

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If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

Your Spouse will have a qualifying event if:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct;

4. You become enrolled in Medicare (Part A, Part B or both); or

5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;

2. Your hours of employment are reduced;

3. Your employment ends for any reason other than gross misconduct;

4. You become enrolled in Medicare (Part A, Part B or both);

5. You and your Spouse become divorced or legally separated; or

6. He or she stops being eligible for coverage under the Plan as a "Dependent".

Special Eligibility Rules Apply

Under special rules that apply to a “health flexible spending arrangement” like the Medical Expense Reimbursement Account Option, the Plan may only be required to offer COBRA coverage if you have an “underspent” Account balance in your Medical Expense Reimbursement Account at the time the qualifying event occurs. You will have an underspent Medical Expense Reimbursement Account balance at the time a Qualifying Event occurs if the amount of reimbursement you were entitled to right before you lost eligibility was greater than the total COBRA premiums you could be charged to continue your Account through the remainder of the Plan Year.

Notifying the Plan Administrator of Qualifying Events

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The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

How to Provide Notice

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

Electing COBRA Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately.

Also, you or your Spouse may elect coverage for your minor children. A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

Length of COBRA Coverage

Under special rules that apply to a “health flexible spending arrangement” like the Medical Expense Reimbursement Account Option, the Plan may only be required to offer COBRA coverage to you or your family members until the end of the Plan Year in which you lose coverage under the Flexible Benefit Plan’s normal eligibility provisions.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

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Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) the Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of COBRA coverage

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

Payment for COBRA coverage-First payment

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Payment for COBRA coverage-Periodic payments

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Grace periods for periodic payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the Plan Administrator**,** or you

may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA

A federal law known as "USERRA" may require that Participants who cease to be eligible to receive health care coverage because of duty in the uniformed services be given the right to buy continued health coverage on an after-tax basis for up to twenty-four months. USERRA also requires that for Participants who are expected to perform service in the uniformed services for less than 31 days, the Employer may not require the Participant to pay more than his or her share, if any, of the premium. With respect to non-health plans, USERRA requires that Participants be given the right to continue participation in the plan on the same basis as any Participant on a non-military leave of absence. To the extent required by applicable federal laws, the Administrator will implement and administer the procedures designed to comply with federal laws requiring the provision of continued coverage and plan participation and will give you notice of your rights under these laws.

MISCELLANEOUS

WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A HEALTH REIMBURSEMENT ARRANGEMENT (“HRA”)?

If you have a health care expense that is considered an eligible expense for purposes of an HRA or a similar supplemental medical reimbursement plan as well as this Plan, the expense must be reimbursed by that other plan to the extent that you have not exceeded your benefit limit under that plan unless the other plan allows unused Account balances to roll forward from Plan Year to Plan Year.

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

Although the Employer presently anticipates the Plan continuing indefinitely, it has the right to amend or terminate the Plan at any time.

WHO PAYS THE COSTS OF THE PLAN?

The cost of administering the Plan is paid by the Employer.

WHAT RIGHTS DO I HAVE UNDER THE LAW AS A PARTICIPANT?

Statement of ERISA Rights. The Medical Expense Reimbursement Account Option is an “employee benefit plan” for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). If you have elected benefits under that option, you are entitled to certain rights and protections under ERISA, including the right to:

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Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

4. Continue your health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

7. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal

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fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

8. If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.

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MORAVIAN COLLEGE

FLEXIBLE BENEFITS PLAN

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MORAVIAN COLLEGE FLEXIBLE BENEFITS PLAN

ARTICLE I: INTRODUCTION

1.1 *Cafeteria Plan Status*. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.2 *Purpose of Plan*. The purpose of this Plan is to provide employees with a choice between taxable compensation and certain non-taxable employee benefits.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 **"Administrator"** means the Plan Sponsor or such other person or committee as may be appointed from time to time by the Plan Sponsor to supervise the administration of the Plan.

2.2 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.3 **"Compensation"** means any wages, salary or other amounts paid in cash by the Employer and reportable on a Participant's Form W-2.

2.4 **"Component Plans"** means the Insurance Plans and Flexible Spending Account Options.

2.5 **"Deemed Election"** means the election of benefits that a Participant will be deemed to have made if he or she fails to file a completed election form for any Period of Coverage on or before the deadline set by the Administrator. A Participant's failure to timely file a completed election form for any Period of Coverage under the Plan shall constitute an election not to receive any benefits under any Flexible Spending Account Option.

2.6 **"Dependent"** means any individual who is a dependent of the Participant as defined in Code §152, with the following exceptions:

(a) For purposes of accident or health coverage including the Medical Expense Reimbursement Account Options, (1) a dependent is defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents. For purposes of accident or health coverage, "Dependent" also includes any child of a Participant who, as of the end of the current calendar year, will not have attained age twenty-seven.

(b) For purposes of the Dependent Care Assistance Account Option, a Dependent means a "qualifying individual" as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, a qualifying individual who is a child shall, as provided in Code §21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent.

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2.7 **"Dependent Care Service Provider"** means a person who provides dependent care, but shall not include (a) a Dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.

2.8 **"Effective Date"** means January 1, 2021.

2.9 **"Eligible Employee"** means an Employee who is of the type, category or classification that is eligible to make an election of benefits under the Plan upon satisfying the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, under the Plan. The Employees who are Eligible Employees are all Employees who regularly are scheduled to perform a minimum of thirty hours of services per week for the Employer; *provided, however, an Eligible Employee who has received or made or will receive or make contributions to a Health Savings Account within the meaning of Section 223(d) of the Code with respect to any portion of a Period of Coverage shall not be eligible to make an election of benefits under the Medical Expense Reimbursement Account Option for that Period of Coverage*.

2.10 **"Employee"** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, short-term employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer but is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

For purposes of this Plan, the following individuals shall not be considered Employees:

(a) If the Employer is an S Corporation, any "2-percent shareholder" of the Employer, as that term is defined by Code Section 1372(b),

(b) If the Employer is a partnership or is taxed as a partnership under federal tax law, any partner, member or owner in the Employer.

(c) If the Employer is a sole proprietorship, the owner of the Employer.

2.11 **"Employer"** means the Plan Sponsor and any other corporation, partnership, firm or business which, with the permission of the Plan Sponsor, adopts the Plan; provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan), the term "Employer" shall mean only the Plan Sponsor. Other parties that adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation therein.

2.12 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.13 **"Flexible Spending Account Option"** means the Medical Expense Reimbursement Account Option or Dependent Care Assistance Account Option described in Article V.

2.14 **"Inactive Participant"** means an individual whose status as a Participant in a Flexible Spending

Account Option has terminated, but who continues to have certain rights to reimbursement under that Plan, in accordance with Article V of the Plan.

2.15 **"Insurance Plan"** means any of the plans, programs and arrangements made available by or through the Employer pursuant to which Employees may obtain insurance (or Health Maintenance Organization) coverage at their own expense (wholly or in part), which are of the following types: NONE.

2.16 **"Insurance Premium Pre-tax Payment Option"** means the option afforded a Participant under the Plan to elect to pay, on a pre-tax basis, his or her share of the cost of coverage under the Insurance Plans. N/A

2.17 **"Key Employee"** means any person who is a key employee, as defined in Section 416(i)(1) of the Code, with respect to the Employer.

2.18 **"Minimum Age Requirement"** means the age, if any, that an Eligible Employee must attain before becoming a Participant. The Plan does not have a Minimum Age Requirement.

2.19 **"Minimum Service Requirement"** means the period of continuous employment with the Employer, if any, that an Eligible Employee must complete before becoming a Participant. The Plan does not have a Minimum Service Requirement.

2.20 **"Participant"** means any Eligible Employee who has satisfied the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, and whose Participant Commencement Date has occurred.

2.21 **"Participation Commencement Date"** means the date on which an Eligible Employee becomes a Participant, which is the first day of the month following the month within which his or her employment with the Employer commences.

2.22 **"Period of Coverage"** means the Plan Year, except as follows: (i) The Period of Coverage for a first-time Participant shall be the period commencing on his or her Participation Commencement Date and ending on the last day of the Plan Year within which his or her Participation Commencement Date occurs, and (ii) The Period of Coverage for a Participant whose participation ceases in accordance with Section 3.2 shall be the period from the first day of the Plan Year within which his or her participation ceases and ending on the date his or her participation ceases.

2.23 **"Plan"** means Moravian College Flexible Benefits Plan as set forth herein, together with any and all amendments and supplements hereto.

2.24 **“Plan Sponsor”** means Moravian College.

2.25 **"Plan Year"** means the period on which the records of the Plan are based, which is the twelve-month period commencing on January 1 and ending on the following December 31.

2.26 **"Qualifying Dependent Care Expense"** mean an expense incurred by a Participant which (a) is incurred for the care of a Qualifying Individual or for related household services, (b) is paid or payable to a Dependent Care Service Provider, and (c) is incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individual with respect to the Participant. "Qualifying Dependent Care Expense" shall not include an expense incurred for (i) services outside the Participant's household for the care of a Qualifying Individual, unless such Qualifying Individual is described in "(a)" above or regularly spends at least eight hours each day

in the Participant's household, or (ii) services at a camp where the Qualifying Individual stays overnight.

2.27 **"Qualifying Expense"** means a Qualifying Dependent Care Expense or Qualifying Medical Care Expense.

2.28 **"Qualifying Individual"** means (a) a Participant's Dependent who is under the age of thirteen (and meets other conditions imposed by the definition of Dependent, such as a requirement that he or she have the same principal place of abode as the Participant); (b) a Participant's Dependent who is physically or mentally incapable of self-care, has the same principal place of abode as the Participant for more than half of the year, and meets other conditions imposed by the definition of Dependent and (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

2.29 **"Qualifying Medical Care Expense"** means an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213(d) of the Code (including, without limitation, amounts paid for hospital bills, doctor, dental or vision care bills and drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under the Plan).

2.30 **"Spouse"** means an individual who is considered a spouse for purposes of the Code.

ARTICLE III: PARTICIPATION

3.1 *Commencement of Participation*. An Eligible Employee shall become a Participant, thus entitling him or her to make an election of benefits under the Plan, on his or her Participation Commencement Date.

3.2 *Cessation of Participation*. A Participant shall cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he or she ceases to be an Eligible Employee. Except as otherwise provided herein, any election made under this Plan (including any Deemed Election) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a Component Plan may continue if and to the extent provided by such Plan.

3.3 *Reinstatement of Former Participant***.** A former Participant will become a Participant again if and when he or she becomes an Eligible Employee. However, a former Participant who becomes re-employed by the Employer within thirty days shall be prohibited from making a new benefit election for the remainder of the Plan Year.

3.4 *Leaves of Absence***.** Subject to any specific limitations for any particular benefit which the Participant has elected:

(a) A Participant's election shall remain in force during a paid leave of absence, i.e., one for which the Participant continues to receive Compensation from the Employer.

(b) A Participant who takes an unpaid leave of absence may revoke his or her existing election and execute a new election for the remainder of the Plan Year to the extent permitted by Section 4.5 below.

(c) Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by FMLA, the

Employer shall continue to maintain the Participant's benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though he or she were still an active Employee (i.e., the Employer must continue to pay its share of the premium to the extent the Employee elects to continue his or her coverage). If the Employee elects to continue his or her coverage, the Employee may pay his or her share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent the Employee receives Compensation during the leave), or the Employee may be given the option to prepay all or a portion of the Employee's share of the premium for the anticipated duration of the leave through a pre-tax salary reduction out of the Employee's pre-leave Compensation by making a special election to that effect prior to the date such Compensation normally would be made available to him or her (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreed upon by the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan and to participate on the same basis as prior to taking leave or as otherwise required by the FMLA, and shall have whatever rights as shall be applicable under Section 4.5.

ARTICLE IV: BENEFIT OPTIONS

4.1 *Benefit Options*. Each Participant may choose, with respect to any Period of Coverage, to receive his or her entire payroll Compensation or to receive benefits under one or more of the Component Plans in lieu of a portion of that Compensation.

4.2 *Insurance Premium Pre-tax Payment Option; Description of Benefits under the Insurance Plans*. The benefits directly available to a Participant relative to the Insurance Plans are limited to receiving his or her entire Compensation or having his or her share of premiums for coverage under the Insurance Plans paid by the Employer in lieu receiving a portion of that Compensation. The types and amounts of insurance benefits available, the eligibility requirements and the other terms and conditions of coverage under the Insurance Plans are as set forth from time to time in those Plans and in the group insurance contracts and prepaid health plan contracts that may constitute (or may be incorporated by reference in) those Plans.

4.3 *Election Procedure*.

(a) *New Participants*. The Administrator shall provide an Eligible Employee with a Flexible Compensation Enrollment Form and Salary Deduction Agreement (or "election form") before, or as soon as practicable after, his or her Participation Commencement Date (or he or she qualifies to make a new election of benefits pursuant to Section 3.3). The Eligible Employee shall specify on the election form those benefits he or she elects for the Period of Coverage to which the election form relates and shall indicate the aggregate amount to be allocated to each of the Component Plans with respect to the Period of Coverage.

(b) *Annual Enrollment and Election Changes*. Before the beginning of each Plan Year, the Administrator shall provide an election form to each Eligible Employee who is scheduled to be a Participant on the first day of that Plan Year. This election form may be used by the Participant to make a new election of benefits under the Plan as of the first day of the Plan Year. The Eligible Employee shall specify on the election form those benefits he or she elects for the Plan Year to which the election form relates and shall indicate the aggregate amount to be allocated to each of the Component Plans with respect to the Period of Coverage.

(c) *Deadline for Return of Election Form.* Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period to which the election form is to apply.

(d) *Failure to Return Election Forms-Deemed Election*. A Participant's failure to return a completed

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election form to the Administrator on or before the specified due date shall constitute a Deemed Election of benefits under the Plan.

4.4 *Election of Component Plan Benefits in Lieu of Payroll Compensation*. If a Participant elects benefits for a Period of Coverage under any of the Component Plans, his or her Compensation for the Period of Coverage shall be reduced in accordance with his or her election form. In the case of benefits elected under any Insurance Plan, the Compensation reduction shall equal the Participant's share of the cost of coverage under that Plan. In the case of benefits elected under any Flexible Spending Account Option, the Compensation reduction shall equal the amount of benefits elected by the Participant under that Option.

4.5 *Irrevocability of Elections.* A Participant may not revoke any election made under the Plan during the Period of Coverage to which it pertains, except as follows:

(a) A Participant may change his or her election for the balance of the Period of Coverage if, under the facts and circumstances, a Change in Status occurs and the change of election satisfies the applicable consistency requirement, as set forth below. For this purpose, a “Change in Status” consists of one of the following events:

(1) A change in the Participant’s legal status, including marriage, death of the Participant’s Spouse, divorce, legal separation or annulment.

(2) A change in the number of Dependents that the Participant has for federal income tax purposes, as determined under Code Section 152, due to events that include birth, adoption, placement for adoption or death.

(3) A termination or commencement of the employment of the Participant or of the Spouse or Dependent of the Participant.

(4) A reduction or increase in the hours of employment of the Participant or the Spouse or Dependent of the Participant, including a switch between part-time and full-time, a strike or lockout and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan, of any other employee benefit plan of the Employer or of any cafeteria plan or other employee benefit plan of the employer of the Participant’s Spouse or Dependent depend on the employment status of that individual and there is a change in that individual’s employment status with the consequence that the individual becomes or ceases to be eligible under the plan, that change constitutes a Change in Status.

(5) An event that causes the Participant’s Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the accident or health plan under which the Participant receives coverage.

(6) A change in the place of residence or work of the Participant or of the Spouse or Dependent of the Participant.

A Participant’s change of election is consistent with a Change in Status only if, (i) the Change in Status results in the Participant or the Participant’s Spouse or Dependent gaining or losing eligibility under an employee benefit plan, and (ii) the change of election corresponds with that gain or loss of coverage, or if the Change of Status affects Qualifying Dependent Care Expenses.

If the Change of Status is a Participant’s divorce, annulment or legal separation, the death of a Participant’s Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election by the Participant to cancel accident or health coverage for any individual other than the Spouse involved in the divorce, annulment or legal separation, the deceased Spouse

or Dependent or the Dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, would fail to correspond with that Change in Status. If a Dependent dies or ceases to satisfy the eligibility requirements for coverage, the election to cancel accident or health coverage for any other Dependent, for the Participant or for the Participant's Spouse also would fail to correspond with that Change in Status. In addition, if a Participant, Spouse or Dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are qualified benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes applicable or is increased under the plan from which eligibility for coverage has been gained.

If the Participant or the Spouse or Dependent of a Participant becomes eligible for continuation coverage under a group health plan of the Employer as provided in Section 4980B of the Code or any similar state law, the Participant may elect to increase payments under this Plan to pay for the continuation coverage.

(b) A Participant may change his or her election for the balance of the Period of Coverage and file a new election that corresponds with special enrollment rights that the Participant exercises under Section 9801(f) of the Code.

(c) In the event of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of a Participant, the Participant may:

(1) change his or her election to provide coverage for the child if the judgment, decree or order requires coverage under the Employer's accident or health plan; or

(2) make a change of election to cancel coverage for the child if the order requires the Spouse or any other person to provide coverage for the child.

(d) If a Participant who is enrolled in an accident or health plan of the Employer or the Spouse of Dependent of such a Participant becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make a prospective change of election to cancel the coverage under the accident or health plan of the Employer of such person. In addition, if a Participant, Spouse or Dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective change of election to commence or to increase coverage for that person under the accident or health plan of the Employer.

(e) A change of cost or change of coverage with respect to benefits under any Component Plan may be the basis for a change of election in accordance with the following:

(1) The rules under this Section "(e)" shall not apply to benefits under the Medical Expense Reimbursement Account Option.

(2) If the cost of a Participant's benefits under any Component Plan increases or decreases during a Period of Coverage and, under the terms of that Component Plan, Employees are required to make a corresponding change in their payments, a corresponding adjustment shall be made to the Participant's elective contributions under this Plan, subject, however, to (3) below.

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(3) If the cost of a Participant's benefits under a Component Plan significantly increases during a period of coverage, the Participant may elect either to increase his or her contributions to pay for the
increased cost or may revoke his or her election and, in lieu thereof, receive on a prospective basis, coverage under another benefit option available under the Component Plan. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which a Participant has elected that benefit or benefit option, a Participant may make a new election of that benefit or benefit option. If a Participant has an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, he or she may revoke that existing election and elect that benefit option that has significantly decreased in cost.

(4) Notwithstanding the foregoing, a cost change shall only provide the basis for an election change with respect to dependent care assistance benefits if the cost change is imposed by a dependent care provider who is not a "relative" of the Participant as that term is defined under Code Section 152.

(5) If a Participant's coverage under any Component Plan is significantly curtailed or ceases during a Period of Coverage, the Participant may revoke his or her existing election of the coverage and may make a new election on a prospective basis of any other coverage option available under that Component Plan. Coverage under an accident or health plan shall be considered as curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(6) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Participant's Spouse, former Spouse or Dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules or if that plan permits participants to make an election for a period of coverage under the cafeteria plan or other plan that is different than that under this Plan.

(f) A Participant may revoke a prior election and make a new election where there has been a significant change in the benefit plan coverage of the Participant, the Spouse of the Participant or a Dependent of the Participant that is attributable to the employment of the Spouse or Dependent, provided such change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

(g) A Participant taking leave under the FMLA may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(h) A Participant who was reasonably expected to average thirty hours of service or more per week and who experiences an employment status change such that he or she is reasonably expected to average less than thirty hours of service per week may prospectively revoke his or her election related to coverage under the group major medical plan of the Employer, provided that the Participant certifies that he or she and any related individuals whose coverage under the group major medical plan of the Employer is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage (as that term is used for purposes of the Affordable Care Act) that is effective no later than the first day of the second month following the month that includes the date as of which coverage under the group major medical plan of the Employer is revoked.

(i) A Participant who is eligible to enroll for coverage in a government-sponsored health insurance

Exchange during an Exchange special or annual open enrollment period may prospectively revoke his or her election related to coverage under the group major medical plan of the Employer, provided that the Participant certifies that he or she and any related individuals whose coverage under the group major medical plan of the Employer is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of coverage under the group major medical plan of the Employer.

Any change of election authorized by this Section must be submitted to the Plan within thirty days after the occurrence of the event to which the election change relates. In the case of an election described in subsection (b) above, the thirty-day period shall commence on the date that the Participant first becomes eligible to exercise special enrollment rights. Notwithstanding the foregoing, if the election corresponds to the exercise of special enrollment rights described in Section 9801(f)(3) of the Code, such election must be submitted to the Plan within sixty days after the Participant or a Dependent of the Participant is determined to be eligible for coverage or loses coverage, as the case may be, under a Medicaid plan as described at Title XIX of the Social Security Act or a State child health plan as described at Title XXI of the Social Security Act.

Any revocation and new election under this Section shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the revocation and new election.

Notwithstanding any provision herein to the contrary, no Participant may reduce his or her election for benefits under any Flexible Spending Account Option below the amount already reimbursed under that Flexible Spending Account Option for the Period of Coverage.

4.6 *Changes by Administrator***.** If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.7 *Additional Benefit Option-HSA Contributions*. In addition to the benefit options described in Section 4.1, a Participant may elect to reduce his or her Compensation by a specified amount and to have that amount contributed by the Employer to a Health Savings Account arrangement maintained by the Employer. Any such election shall be consistent with the procedures set forth above in this Article IV.

Notwithstanding any other provision herein to the contrary, any election made pursuant to this Section 4.7 may be modified not less than once per month.

4.8 *Maximum Employer Contributions*. The maximum amount of contributions to the Plan for any Participant shall be the sum of (i) the cost from time to time of the most expensive benefits available to the Participant under the Insurance Premium Pre-tax Payment Option, (ii) the maximum amount that may be contributed for benefits under the Flexible Spending Account Option, and (iii) the maximum amount that may be contributed for benefits under the Health Savings Account arrangement maintained by the Employer.

ARTICLE V: FLEXIBLE SPENDING ACCOUNT BENEFITS

5.1 *Flexible Spending Account Options.*

(a) *Health Care*. There is hereby created a “self-insured medical expense reimbursement plan" as

defined at Section 105(h) of the Code, the purpose of which shall be to provide Participants with nontaxable reimbursements of Qualifying Medical Care Expenses (the "Medical Expense Reimbursement Account Option").

(b) *Dependent Care.* There is hereby created a "dependent care assistance program" as defined at Section 129 of the Code (the "Dependent Care Assistance Account Option"). The purpose of the Dependent Care Assistance Account Option shall be to provide Participants with reimbursements of Qualifying Dependent Care Expenses that are excludable from income.

5.2 *Status as Flexible Spending Arrangements*. Each Flexible Spending Account Option shall operate in all respects in accordance with the rules applicable to a "flexible spending arrangement" as set forth in Proposed Income Regulation Section 125-5(a) and any successor IRS regulations and guidance.

5.3 *Establishment of Accounts.* If a Participant elects benefits under a Flexible Spending Account Option for any Period of Coverage, the Administrator shall establish an Account on the books of the Plan with respect to his or her election and shall maintain the Account in accordance with the rules set forth below in this Article V. Any such Account is for record-keeping purposes only and does not involve any actual segregation of assets.

5.4 *Crediting of Accounts.*

(a) *Medical Expense Reimbursement Account*. The Account of a Participant that is established on account of an election of benefits under the Medical Expense Reimbursement Account Option (the "Medical Expense Reimbursement Account") shall be credited with an amount equal to his or her benefit election for that Period of Coverage. This amount shall be credited to the Participant as of the first day of the Period of Coverage.

In addition, an amount may be credited to a Medical Expense Reimbursement Account in accordance with Section 5.11(c) below.

(b) *Dependent Care Assistance Account*. The Account of a Participant that is established on account of an election of benefits under the Dependent Care Assistance Account Option (a "Dependent Care Assistance Account") shall be credited with the amount of contributions that are made to that Account in accordance with Article IV at the time the contributions occur.

5.5 *Maximum Electable Benefit Amounts.* The maximum (and minimum, where applicable) amount of benefits that a Participant may elect for a Period of Coverage is as follows:

(a) *Medical Expense Reimbursement Account Option*: The maximum amount shall be the highest amount permitted by Section 125(i) of the Code on the effective date of the Participant's election. The minimum amount shall be $24. An otherwise applicable amount shall be reduced proportionately with respect to a benefits election for a Period of Coverage consisting of fewer than twelve months.

(b) *Dependent Care Assistance Account Option:* The maximum amount shall be $5,000.

5.6 *Code Limits on Dependent Care Assistance*. The maximum amount that a Participant may receive for reimbursement of Qualifying Dependent Care Expenses in any calendar year shall be the least of (a) the Participant's earned income for the calendar year (after all reductions in compensation including the reduction related to dependent care assistance), (b) the actual or deemed earned income of the Participant's Spouse for the calendar year, if the Participant is married, or (c) $5,000 (or, if the Participant does not certify to the Administrator's satisfaction that he or she is either unmarried or will file a joint Federal income tax return for the year, $2,500). In the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such Spouse shall be deemed to have

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earned income of not less than $250 per month if the Participant has one Qualifying Individual and $500 per month if the Participant has two or more Qualifying Individuals. In the case of two Participants who are married to each other and who file a joint Federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the year under this Plan by the Participant's Spouse. For purposes of this Section, "earned income" shall have the meaning given it by Section 32(c)(2) of the Code, and a Participant shall not be treated as married if the Participant is not considered as married under the special rules of Code Section 21(e)(3) and (4).

5.7 *Debiting of Accounts*. A Participant's Account under a Flexible Spending Account Option shall be reduced by the amount of claims paid from the Account.

5.8 *Claims for Reimbursement.* A Participant shall obtain reimbursement of a Qualifying Expense by submitting a claim on a form provided by the Plan. Each claim must include:

(a) a description of the Qualifying Expense, the amount of the Expense and the date on which the Expense was incurred.

(b) the person paid or to be paid.

(c) the name of the person who incurred the Expense.

(d) bills, invoices, receipts or other documentation showing the amounts of the expenses incurred.

(e) if the expense is a Qualifying Medical Care Expense, a certification that the expense has not already been reimbursed by another health plan and is not eligible for reimbursement under any other health plan.

(f) if the expense is a Qualifying Dependent Care Expense, the name, address and taxpayer identification number of the dependent care provider.

5.9 *When an Expense is Incurred.* A claim may be submitted before or after the Participant has paid a Qualifying Expense, but not before the Expense has been incurred. A Qualifying Expense shall be deemed incurred at the time the services giving rise to the Expense are rendered.

5.10 *Direct Payment Option*. The Administrator may, at its option, pay any Qualifying Expense directly to the person providing or supplying the services that gave rise to the Expense, in lieu of reimbursing the Participant.

5.11 *Amount Available For Payment of Claims.*

(a) *Medical Expense Reimbursement Account Option Claims.* Subject to (c) below, the amount available to reimburse a Participant for Qualifying Medical Care Expenses on a particular date during a Period of Coverage shall equal the amount of his or her benefit election then in effect reduced by the total reimbursement he or she already has received for such expenses during the Period of Coverage.

(b) *Dependent Care Assistance Account Option Claims.* The amount available to reimburse a Participant for Qualifying Dependent Care Expenses on a particular date during a Period of Coverage shall equal the total salary reduction contributions credited to his or her Dependent Care Assistance Account as of that date reduced by the total reimbursement he or she already has received for such expenses during the Period of Coverage.

(c) *Medical Expense Reimbursement Account Carryover.* Should a Participant have a positive balance credited to a Medical Expense Reimbursement Account on the last day of a Plan Year, the remaining

balance to a maximum of $500.00 shall be carried over and credited to a Medical Expense Reimbursement Account for his or her benefit as of the first day of the following Plan Year.

The amount carried over (the "Carryover Amount") shall remain available to reimburse claims for Qualified Medical Care Expenses incurred during the preceding Plan Year that are submitted by the date specified in Section 5.12. The Carryover Amount also shall be available to reimburse claims for Qualified Medical Care Expenses incurred during the following Plan Year once the entire amount credited to Participant's Medical Expense Reimbursement Account pursuant to his or her benefits election for the following Plan Year has been expended. However, the amount available to reimburse Qualified Medical Care Expenses incurred during the preceding Plan Year shall be reduced by the portion of the Carryover Amount used to pay Qualified Medical Care Expenses incurred during the following Plan Year.

(d) *Waiver of Carryover.* A Participant to whom subsection (c) above otherwise would apply may decline a carryover by communicating to the Plan Administrator his or her desire to do so before the carryover is credited to a Medical Expense Reimbursement Account in the following Plan Year.

5.12 *Deadline for Claims Submission.* A Participant must submit a claim for reimbursement from his or her Flexible Spending Account by March 31st of the Plan Year following the Plan Year with respect to which the Account was established. The Administrator shall not pay any claim submitted after that date.

5.13 *Code Limitations on Reimbursements to Certain Participants*.

(a) *Nondiscriminatory Benefits*. Each of the Flexible Spending Account Options is intended not to discriminate as to eligibility to participate or benefits in favor of highly compensated individuals or highly compensated employees, as the case may be as those terms are defined in the applicable provisions of the Code. If, in the judgment of the Administrator, the operation of the Plan in any Plan Year would result in such discrimination, the Administrator may take such remedial action as the Administrator deems necessary or appropriate to assure that the Plan does not discriminate, including but not limited to, restricting the amounts reimbursed to such persons or excluding such persons altogether from participation. Such remedial actions may be taken whether or not to do so would result in a forfeiture of any Account balance.

(b) *Dependent Care Assistance Account Option.* The following rules shall apply to the operation of the Dependent Care Assistance Account Option:

(1) Not more than twenty-five percent of the total amount reimbursed under the Dependent Care Assistance Account Option during any Plan Year may be reimbursed with respect to Participants who own more than five percent of the stock or of the capital or profits interest of the Employer (or their Spouses or Dependents).

(2) The average benefits provided to Participants who are not highly compensated employees must be at least fifty-five percent of the average benefits provided to highly compensated employees (within the meaning of Code Section 414(q)) under all dependent care Assistance Account Options of the Employer. For purposes of this limitation, in the case of any benefits provided through a salary reduction agreement, any Participant whose compensation is less than $25,000 may be disregarded. Also, for the purposes of the foregoing, there shall be excluded from consideration employees who are described in Code Section 129(d)(9).

5.14 *Forfeiture of Unused Account Balances*. Except as described in Section 5.11(c) above, any balance that remains credited to a Flexible Spending Account after all authorized reimbursements for a Period of Coverage have been made shall not be carried over to reimburse the Participant for Qualifying Expenses incurred during a subsequent Period of Coverage and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with

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respect to such balance. The Employer may use any forfeited account balances to pay any administrative expenses of the Plan or in any other manner that does not violate ERISA or any other applicable law or regulation. For this purpose, "administrative expense" shall include any amount by which the benefits paid to any Participant under the Medical Expense Reimbursement Account Option for any Period of Coverage exceeded the Participant's contributions to the Medical Expense Reimbursement Account Option for that Period of Coverage.

5.15 *Inactive Participant Status.* Except as hereinafter provided, an individual shall cease to be a Participant with respect to a Flexible Spending Account Option and become an Inactive Participant with respect to same when he or she ceases to be a Participant pursuant to Section 3.2 or when his or her election for benefits under that Flexible Spending Account Option expires, whichever first occurs. An individual who has the status of Inactive Participant with respect to any Flexible Spending Account Option may submit further claims for reimbursement of Qualifying Expenses only in accordance with the following:

(a) An Inactive Participant for whom a Medical Expense Reimbursement Account had been established for the Period of Coverage within which he or she became an Inactive Participant and who had a positive balance credited to that Account on the date he or she became an Inactive Participant may continue to submit claims for the reimbursement of Qualifying Medical Care Expenses incurred during that Period of Coverage. Any such claims must be submitted by no later than March 31st of the Plan Year following the Plan Year within which said Period of Coverage ended.

(b) An Inactive Participant for whom a Dependent Care Assistance Account had been established for the Period of Coverage within which he or she became an Inactive Participant and who had a positive balance credited to that Account on the date he or she became an Inactive Participant may continue to submit claims for the reimbursement of Qualifying Dependent Care Expenses incurred during that Period of Coverage or during the remainder of the Plan Year within which the Period of Coverage ended. Any such claims must be submitted by no later than March 31st of the following Plan Year.

5.16 *Continuation Coverage under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA")*. The Plan shall comply with the requirements of COBRA or any other applicable federal or state law granting continuation benefits upon termination of coverage to the extent applicable.

ARTICLE VI: ADMINISTRATION OF PLAN

6.1 *Plan Administrator.* The Administrator shall administer the Plan in accordance with its terms without discriminating among the Participants. The Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under any of the Insurance Plans shall not be subject to review under this Plan, and the Administrator's authority under this Section 6.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

6.2 *Examination of Records.* The Administrator shall make available to each Participant such of his or her records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

6.3 *Reliance on Tables, etc.* In administering the Plan, the Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Component Plans, or by accountants, counsel or other experts employed or engaged by the Administrator.

6.4 *Indemnification of Administrator.* The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by an act or omission to act in connection with the Plan, if such act or omission is in good faith and was not the product of gross negligence.

6.5 *Named Fiduciary.* The Plan Administrator will be the “named Fiduciary” for purposes of Section 402(a)(1) of ERISA with the authority to control and manage the operation and administration of the Plan and will be responsible for complying with all of the reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA; provided, however, the Manager of Flex & Claims Administration of P&A Administrative Services, Inc. shall be the named Fiduciary with respect to the appeal of denied claims.

ARTICLE VII: CLAIMS

7.1 *Filing of Claims*. The Plan Administrator has retained P&A Administrative Services, Inc. of Buffalo, New York (the “Claims Administrator”) to process all claims. Information regarding incurred expenses eligible for reimbursement under this Plan shall be submitted directly to the Claims Administrator to determine the amount of any benefits payable hereunder.

7.2 *Appeals Procedure.* If a claim for reimbursement is denied in whole or in part, the appeals procedures described in the Summary Plan Description or Plan Summary for this Plan shall apply.

7.3 *Scope of Claims Review under this Plan*. Except to the extent otherwise specifically provided herein, any claim for benefits under an Insurance Plan shall be governed by the claims procedures that are included in the plan documents pursuant to which that Plan is maintained. The claims procedures for this Plan shall apply to (i) any partial or total denial of benefits under any Flexible Spending Account Option, and (ii) any denial of benefits due to an issue germane to the claimant's coverage under the Flexible Benefits Plan (e.g., whether a Change in Status has occurred).

7.4 *Use of Electronic Payment Card System.* If approved and implemented by the Administrator, Participants may use electronic payment cards to obtain payment of benefits to which they are entitled under

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the Medical Expense Reimbursement Account Option and/or the Dependent Care Assistance Account Option. Any use of electronic payment cards in connection with this Plan shall comply with all pertinent laws, regulations and then current guidance from the Internal Revenue Service.

ARTICLE VIII: AMENDMENT AND TERMINATION OF PLAN

The Plan Sponsor may amend or terminate the Plan at any time.

ARTICLE IX: MISCELLANEOUS PROVISIONS

9.1 *Information to be Furnished.* Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

9.2 *Limitation of Rights*. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein.

9.3 *Benefits Solely From General Assets.* Except as may otherwise be required by law:

(a) Any amount by which a Participant's Compensation is reduced under this Plan will remain part of the general assets of the Employer;

(b) Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

(c) No Participant or other person shall have any claim against, right to or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

9.4 *Use and Disclosure of Protected Health Information.*

(a) Members of the Employer’s workforce have access to the individually identifiable health information of Participants for Plan administrative functions. When this information is provided by the Plan to the Employer, it is "protected health information" ("PHI"). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Employer’s ability to use and disclose PHI. The following definition of PHI applies for purposes of this Section 9.4:

> *Protected Health Information*. Protected health information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted under HIPAA. HIPAA and the implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (“HITECH”), the statutory provisions of which are incorporated herein by reference.

(b) The Plan may disclose to the Employer whether a particular individual is a Participant.

(c) The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests it for the purpose of modifying, amending or terminating the Plan. For this purpose,

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“Summary Health Information” means information (a) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan, and (b) from which the information described in 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(d) Unless otherwise permitted by law, and subject to the conditions of disclosure described in (e) below, and obtaining written certification in accordance with (g) below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses it only for Plan administration purposes. “Plan administration purposes” means administrative functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. The term does not include functions performed by the Employer in connection with any other benefit plan or any employment-related functions.

Notwithstanding any provision of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR section 164.504(f).

(e) The Employer agrees that with respect to any PHI disclosed to it by the Plan (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer shall:

(1) not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

(2) ensure that any agent, including a subcontractor, to whom the Employer provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

(3) not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;

(4) report to the Plan any unauthorized use or disclosure of PHI that it becomes aware of;

(5) make PHI available to comply with HIPAA's rights to access in accordance with 45 CFR section 164.524;

(6) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR section 164.526;

(7) make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528;

(8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA’s privacy requirements;

(9) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which it disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

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(10) ensure that the adequate separation between the Plan and the Employer (the "firewall") required by 45 CFR section 504(f)(2)(iii) is maintained.

The Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

(f) The Employer shall allow the following persons access to PHI: its Director of HRA-HRIS & Benefits, and any other Employee who needs access to PHI to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll and appeals). No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's disciplinary and termination procedures.

The Employer shall ensure that the provisions of this (f) are supported by reasonable and appropriate security measures.

(g) The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan incorporates the provisions of 45 CFR section 504(f)(2)(ii) and that the Employer agrees to the conditions of disclosure set forth in (e) above.

9.5 *Governing Law*. This Plan shall be construed, administered and enforced according to the laws of the State wherein the principal office or place of business of the Employer is located, except to the extent preempted by ERISA.

9.6 *Complete Document.* This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Employer document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions, and the remainder of the Plan document shall continue in full force and effect.

9.7 *Coordination of Benefits.* Notwithstanding any other provision herein to the contrary, should a Participant incur an eligible expense for purposes of both this Plan and any health reimbursement arrangement or similar type of supplemental self-insured medical expense reimbursement plan or arrangement that includes an Account balance rollover feature, he or she shall be obligated to submit a claim for reimbursement of that expense by this Plan and may only submit the expense for reimbursement by the other plan or arrangement if this Plan fails to fully reimburse him or her for the expense.

9.8 *Effect of Mistake.* If a mistake occurs as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively feasible and otherwise permissible under Code Section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly

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entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

IN WITNESS WHEREOF, the Plan Sponsor has adopted the Plan as of the Effective Date. In signing below, the Plan Sponsor hereby certifies that the Plan incorporates the provisions of 45 CFR section 164.504(f)(2)(ii) as set forth in Section 9.4(e) above and agrees to the limitations on the disclosure of PHI described therein.

MORAVIAN COLLEGE

DocuSigned by:

By: Hope Meixell

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Title: Associate Director of HR - HRIS & Benefits

FLEXIBLE BENEFITS ADMINISTRATION SERVICES AGREEMENT

This Agreement made effective as of January 1, 2021 (the "Effective Date"), by and between **MORAVIAN COLLEGE**, 1200 Main Street, Bethlehem, PA 18018 (the **"Employer"**), and **P&A ADMINISTRATIVE SERVICES, INC.**, 17 Court Street, Suite 500, Buffalo, NY 14202-3294 (**"P&A"**).

W I T N E S S E T H:

WHEREAS, the Employer desires to establish a cafeteria plan as defined in Section 125 of the Internal Revenue Code for eligible employees (the "Plan"); and

WHEREAS, the Employer desires to retain P&A to provide administrative services with respect to the Plan, and P&A desires to provide such services upon certain terms and conditions;

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, receipt of which is hereby acknowledged, the parties hereto, with the intention of being legally bound hereby, covenant and agree as follows:

1. Services. P&A shall provide the following services with respect to the Plan:

a. prepare such Plan documents as shall be necessary to properly establish the Plan as of the Effective Date, including a formal Plan document, a summary of the material provisions of the Plan for distribution to employees eligible to participate in the Plan ("Participants"), and a form to be used by Participants enrolling in the Plan. At the time provided to the Employer, such documents shall conform in all respects with applicable law, regulations and governmental guidance;

b. with the assistance of the Employer, enroll Participants in the Plan;

c. provide to each Participant who elects benefits under the Plan's Medical Expense Reimbursement Account benefit option or Dependent Care Assistance Account option an electronic payment card that may be used to pay expenses that are eligible for reimbursement under that benefit option, and such additional cards for use by family members of the Participant as he or she reasonably shall request;

d. substantiate the eligibility of expenses paid by use of an electronic payment card to the extent required by applicable law;

e. provide Participants who have elected flexible spending account benefits under the Plan with a form to use in submitting flexible spending account claims;

f. receive, review and, when authorized by the Plan and by applicable law, approve flexible spending account claims;

g. from time to time, notify the Employer of the aggregate amount of funds needed from the Employer to pay pending approved claims and receive said funds as transmitted

by the Employer;

h. pay approved flexible spending account claims from funds made available by the Employer for that purpose. Claims shall be paid by check or, where authorized by a claimant, by direct electronic deposit to a bank account of the claimant;

i. provide with each flexible spending account claim paid by check a statement of the Participant's remaining account balance under the flexible spending account from which the payment has been made;

j. before the end of each Plan Year of the Plan as described in the Plan document (the “Plan Year”), provide to each Participant who elected any flexible spending account benefits for that Plan Year a statement setting forth each of his or her flexible spending account balances and advise of the potential forfeiture of any balances not used to reimburse the Participant for eligible expenses incurred prior to the end of that Plan Year;

k. perform such benefits discrimination testing as P&A shall deem necessary to assure the Plan's continuing compliance under Code Section 125; and

l. upon request, prepare any annual return (Form 5500 Series or equivalent) required by applicable federal law with respect to the Plan for filing by the Employer with respect to each Plan Year ending prior to the termination of this Agreement.

2. Compensation. As compensation for the services rendered hereunder, the Employer shall pay P&A such fees as are set forth in Schedule A attached hereto and made a part hereof. P&A may modify this fee schedule as of the beginning of any Plan Year commencing on or after the initial term of the Agreement (as described in Section 5 hereof). P&A shall notify the Employer in writing of any modification to the fee schedule not less than ninety (90) days before the beginning of the Plan Year in which the modification is to become effective. Should the Employer be unwilling to accept any such modification, it may exercise its right to terminate the Agreement in accordance with Section 5 below.

3. Employer Responsibilities.

a. The Employer shall notify P&A in writing of any event or occurrence that affects the group of employees who are eligible for reimbursement of expenses under the Plan (e.g., hiring of a new employee, termination of an employee, change in hours worked) as soon as is reasonably practicable.

b. The Employer shall provide P&A on a timely basis with such other information as P&A reasonably shall request in furtherance of its responsibilities hereunder as soon as is reasonably practicable.

c. The Employer shall provide P&A with the funds necessary to pay all claims that qualify for reimbursement under the Plan. P&A shall not be obligated to advance funds to

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the Employer for this purpose.

d. The Employer shall be responsible for assuring that withholding from its payroll is consistent in all respects with salary reduction elections made under the Plan and for preparing Forms W-2 that reflect benefits that were received by Participants during the reporting year to the extent required by law.

4. Responsibilities of the Parties and Indemnification. The responsibilities and liabilities of P&A are only those set forth herein, and no others shall be implied. P&A shall have no duty or authority to make, or to compel the Employer to make payment of any benefit under the Plan. Except for its own misconduct or negligence, P&A shall not indemnify the Employer or any other provider of benefits under the Plan, with respect to its liability to pay benefits to Participants.

Except for its own misconduct or negligence, neither P&A nor any of its officers, directors, or employees, nor any agent of or counsel for any of the foregoing, shall be liable to anyone at any time interested in the Plan, for any act or omission in providing services hereunder. P&A shall indemnify and hold harmless the Employer from any claim, liability, obligation or charge arising out of P&A's misconduct, negligence or other wrongdoing in connection with activities or responsibilities arising out of or relating to this Agreement. The Employer shall indemnify and hold harmless P&A from any claim, liability, obligation or charge arising out of the Employer's misconduct, negligence or other wrongdoing in connection with activities or responsibilities arising out of or relating to this Agreement.

5. Term; Termination. The initial term of this Agreement shall commence on the Effective Date and shall end on the last day of the first twelve-month Plan Year commencing on or after that date. Thereafter, this Agreement automatically shall be renewed for each additional Plan Year unless one of the parties hereto gives the other party notice in writing of its desire to terminate the Agreement as of the end of a specified Plan Year not less than sixty (60) days prior to the end of that Plan Year. Notwithstanding the foregoing, this Agreement shall terminate (a) automatically if either party is adjudicated a bankrupt or suffers appointment of a temporary or permanent receiver, trustee or custodian for all or a substantial part of their assets, which shall not be discharged within thirty (30) days of appointment, or makes an assignment for the benefit of creditors, or (b) after written notice by one party of the other party's material breach of, or material failure to perform, its obligations hereunder unless such breach or failure is cured within ten (10) days of said notice. Any notice of breach must provide all such details as are known to the non-breaching party regarding the nature of the other party's alleged breach, the specific obligation hereunder to which the alleged material breach relates, the approximate date on which the alleged breach occurred and the identity of any personnel of the other party that were involved. Failure to provide such detail shall render said notice null and void for purposes of this Agreement.

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Should the Employer cause this Agreement to be terminated other than in accordance with the preceding paragraph, the Employer immediately shall become obligated to pay P&A as liquidated damages an amount equal to seventy-five percent of the fees that would have been due had the Agreement remained in effect for the period (i) commencing on the date next following the date on which the Agreement prematurely was or will become terminated, and (ii) ending on the earliest date as of which the Employer properly could have terminated the Agreement by giving the advance notice prescribed hereunder on the date the Employer first notified P&A in writing of the Employer's intention to terminate the Agreement. For purposes of calculating this liquidated damages amount, the fees due to P&A hereunder for services it provided in the month preceding the month within which P&A first was notified of the premature termination of the Agreement shall be the fees due for each month during the period described in the preceding sentence.

6. Confidentiality. All books and records, including the data therein, pertaining to each party which may come into the hands of the other are to be treated as confidential and private records, and the other party shall not disclose information from such records unless it is required by law or authorized by the initial party in writing prior to such disclosure. Both parties reserve the right to control the use of any of their symbols, trademarks, computer programs and service marks currently existing or hereafter established. Both parties agree that they will not use the computer programs work, symbols, trademarks, service marks, or other devices of the other in advertising, promotional material, or otherwise and will not advertise or display such devices without the prior written consent of the other party. In addition, both parties further agree that any such work, symbols, trademarks, service marks, or other devices furnished by one party to the other shall remain the property of the initial party and shall be returned by the other party upon demand of the initial party upon termination of this Agreement.

7. HIPAA Compliance. The parties hereto acknowledge that they have entered into a separate Business Associate Agreement of even date herewith (the Employer on behalf of the Plan), a copy of which is appended hereto as Exhibit 1, and agree that said Business Associate Agreement and all of the obligations and rights of the parties thereunder shall be incorporated herein by reference.

8. Binding Effect. This Agreement shall inure to the benefit of and be binding upon the parties, their legal representatives, contractors, agents, successors and assigns.

9. Integration. By their making of this Agreement, the parties hereto hereby acknowledge that this Agreement supersedes any previous understandings between them with respect to all matters contained herein and contains the entire understanding and agreement between them with respect to all matters contained herein and cannot be amended, modified or supplemented except by a subsequent written agreement entered into by both parties.

10. Subcontracting. P&A shall not subcontract any portion of this Agreement without the prior

written approval of the Employer.

11. Non-Exclusive Arrangement. Nothing contained herein shall be construed to prevent either party from independently operating or participating in any other agreement concerning plan administration services independent and unrelated to the services and obligations of the parties pursuant to this Agreement.

12. Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed as a waiver of a breach or violation of any other provision of this Agreement or of any subsequent breach or violation thereof.

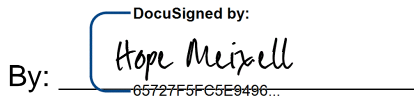
13. Severability. In the event any provision of this Agreement is rendered invalid or unenforceable, the remaining provisions of this Agreement shall remain in full force and effect.

14. Enforcement. If any action at law or in equity (including arbitration) is necessary to enforce or interpret any one or more of the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which such party may be entitled.

15. Notice. Any notice hereunder by either party shall be deemed to have been duly given three (3) business days after mailing, and shall be given by fax and by being mailed in any post office or post office box maintained by the United States Postal Service, enclosed in a postage paid envelope, registered or certified mail, return receipt requested, addressed to the party to whom or which notice is intended to be given at such party's address as stated above or to such other address as each party shall specify in writing to the other.

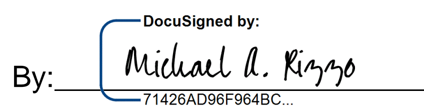
IN WITNESS WHEREOF, the parties have entered into this Agreement as of the Effective Date.

MORAVIAN COLLEGE

By: 

Title: Associate Director of HR - HRIS & Benefits

P&A ADMINISTRATIVE SERVICES, INC.

By: 

Title: President

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SCHEDULE A-FEES

The Employer will pay to P&A:

1. ***INSTALLATION FEE.*** A fee of $300.00 for all of those services relating to the installation of the Plan, including preparation of Plan documents, data entry and processing of enrollment forms. P&A shall extract this fee by ACH from a bank account designated by the Employer (the "Employer's Account").

2. ***ADMINISTRATION FEES.*** Administration fees for each calendar month commencing while this Agreement remains in effect.

After open enrollment of Plan Participants has been completed for each Plan Year, P&A shall determine if an Annual Minimum Fee in the amount of $1,250.00 is due with respect to that Plan Year. This Annual Minimum Fee shall be due only if the following total is less than $1,250.00: The number of Plan Participants who enrolled in any of the Plan's Flexible Spending Account options during open enrollment multiplied by $3.65 (the per Participant monthly fees described below) then multiplied again by 12 months.

If it is determined, with respect to a particular Plan Year, that the Annual Minimum Fee provision above does not apply, P&A shall begin during the second month of that Plan Year to extract by ACH from the Employer's Account the administration fees due for services performed during the preceding month. The fees for a given month shall equal $3.65 for each individual who was eligible for the reimbursement of expenses under any of the Plan's Flexible Spending Account options as of the first day of that month on account of a salary reduction agreement in effect on that date or otherwise, including (i) any individual who, on that date, would have been eligible for reimbursement under any of the Plan's Flexible Spending Account options but for the fact that he or she previously was reimbursed for the full amount of his or her benefit election for the Plan Year; (ii) any individual whose eligibility to make additional salary reduction contributions to the Plan had terminated prior to that date but who, on that date, remained eligible to submit post-termination run-out claims under the terms of the Plan; and (iii) any individual who had elected COBRA coverage prior to that date and whose COBRA coverage remained in effect on that date)

If it is determined to apply with respect to a Plan Year, P&A shall extract the Annual Minimum Fee from the Employer's Account. Once extracted, this Annual Minimum Fee shall be credited against the Employer's obligation for monthly fees as determined in accordance with the preceding paragraph, and P&A shall not send the Employer an invoice for any monthly fees until the total of all such fees accrued to date exceeds the amount of the Annual Minimum Fee.

3. ***ANNUAL REPORT PREPARATION***. $300.00 for each annual return (Form 5500 Series or equivalent) that is prepared by P&A pursuant to Section 1 of this Agreement.

4. ***REQUESTED ADDITIONAL SERVICES AND MATERIALS.*** For such services and materials requested by the Employer that are in addition to the services and materials described in Section 1 of this Agreement, P&A shall be entitled to such additional compensation from the requesting party as is mutually agreed upon by the requesting party and P&A.

5. ***MAILING EXPENSES***. The cost of any mailing required under the Agreement the rate for which exceeds the first class rate charged by the U.S. Post Office.

6. ***RECOUPMENT OF PENALTIES AND FEES.*** The amount of any penalty or like fee that is imposed on P&A as a result of any action or inaction by the Employer or by the employees or other agents of the Employer with respect to the administration of the Plan, including but not limited to returned check charges or ACH rejection fees. P&A shall be entitled to

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immediately recoup any such penalty or fee from the Employer after giving the Employer written notice that P&A has paid such amount.

Note: Should the Employer elect to change the terms of the Plan or should changes in applicable laws necessitate changes to the Plan documents, P&A will provide the Employer with a quote as to the cost of having P&A make the document changes.

BUSINESS ASSOCIATE AGREEMENT

This Agreement made effective as of January 1, 2021 (the "Effective Date"), by and between the Covered Entity identified below, and **P&A ADMINISTRATIVE SERVICES, INC.**, 17 Court Street, Suite 500, Buffalo, NY 14202-3294 (**"Business Associate"**).

1. *Definitions.*

a. **Breach.** "Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.

b. **Breach Notification Rule.** "Breach Notification Rule" shall mean the Standards and Implementation Specifications for Notification of Breaches of Unsecured Protected Health Information under 45 CFR Parts 160 and 164, subparts A and D.

c. **Business Associate.** "Business Associate" shall mean P&A Administrative Services, Inc.

d. **Covered Entity.** "Covered Entity" shall mean the Medical Expense Reimbursement Account Option under the Moravian College Flexible Benefits Plan.

e. **Electronic Protected Health Information.** "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103.

f. **Electronic Transactions Rule.** "Electronic Transactions Rule" shall mean the final regulations issued by HHS concerning standard transactions and code sets under 45 CFR Parts 160 and 162.

g. **Enforcement Rule.** "Enforcement Rule" shall mean the Enforcement Provisions set forth in 45 CFR Part 160.

h. **Genetic Information.** "Genetic Information" shall have the same meaning as the term "genetic information" in 45 CFR § 160.103.

i. **HHS.** "HHS" shall mean the Department of Health and Human Services.

j. **HIPAA Rules.** "HIPAA Rules" shall mean the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule.

k. **HITECH Act.** "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

l. **Privacy Rule.** "Privacy Rule" shall mean the Privacy Standards and Implementation Specifications at 45 CFR Parts 160 and 164, subparts A and E.

m. **Protected Health Information.** "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received,

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maintained, or transmitted by Business Associate from or on behalf of Covered Entity pursuant to this Agreement.

n. **Required by Law.** "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.

o. **Security Incident.** "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

p. **Security Rule.** "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR Parts 160 and 164, subparts A and C.

q. **Services Agreement.** "Services Agreement" shall mean the "Flexible Benefits Plan Services Agreement" of even date herewith between Moravian College and the Business Associate including any subsequent amendments or restatements thereof.

r. **Subcontractor.** "Subcontractor" shall have the same meaning as the term "subcontractor" in 45 CFR § 160.103.

s. **Transaction.** "Transaction" shall have the meaning given the term "transaction" in 45 CFR § 160.103.

t. **Unsecured Protected Health Information.** "Unsecured Protected Health Information" shall have the meaning given the term "unsecured protected health information" in 45 CFR § 164.402.

2. ***Privacy and Security of Protected Health Information.***

a. **Permitted Uses and Disclosures.** Business Associate is permitted to use and disclose Protected Health Information only as set forth below:

(i) Functions and Activities on Covered Entity's Behalf. Business Associate shall provide the services described in a certain administrative services agreement of even date herewith (the "Services Agreement"). The Business Associate hereby is authorized to de-identify Protected Health Information whenever, in its best judgment, it is necessary to do so to comply with the HIPAA Rules.

(ii) Business Associate's Operations. Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out Business Associate's legal responsibilities, provided that—

(A) The disclosure is Required by Law; or

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(B) Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Protected Health Information that the person or entity will—

(1) Hold the Protected Health Information in confidence and use or further disclose the Protected Health Information only for the purpose for which Business Associate disclosed Protected Health Information to the person or entity or as Required by Law; and

(2) Promptly notify Business Associate of any instance of which the person or entity becomes aware in which the confidentiality of Protected Health Information was breached.

(iii) Minimum Necessary. Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate nor Covered Entity is required to limit its use, disclosure, or request to the minimum necessary under the HIPAA Rules. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HITECH Act and the HIPAA Rules.

b. **Prohibition on Unauthorized Use or Disclosure.** Business Associate will neither use nor disclose Protected Health Information, except as permitted or required by this Agreement or in writing by Covered Entity or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Covered Entity's Protected Health Information in a manner that would violate the HIPAA Rules if done by Covered Entity, except as permitted for Business Associate's proper management and administration, as described above.

c. **Information Safeguards.**

(i) Privacy of Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information. The safeguards must reasonably protect Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. To the extent the parties agree that the Business Associate will carry out directly one or more of Covered Entity's obligations under the Privacy Rule, the Business Associate will comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.

(ii) Security of Covered Entity's Electronic Protected Health Information. Business Associate will comply with the Security Rule and will use appropriate administrative, technical, and physical

safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf.

(iii) No Transfer of PHI Outside United States. Business Associate will not transfer Protected Health Information outside the United States without the prior written consent of the Covered Entity. In this context, a "transfer" outside the United States occurs if Business Associate's workforce members, agents, or subcontractors physically located outside the United States are able to access, use, or disclose Protected Health Information.

d. **Subcontractors.** Business Associate will require each of its Subcontractors to agree, in a written agreement with Business Associate, to comply with the provisions of the Security Rule; to appropriately safeguard Protected Health Information created, received, maintained, or transmitted on behalf of the Business Associate; and to apply the same restrictions and conditions that apply to the Business Associate with respect to such Protected Health Information.

e. **Prohibition on Sale of Protected Health Information.** immediately, Business Associate shall not engage in any sale (as defined in the HIPAA rules) of Protected Health Information.

f. **Prohibition on Use or Disclosure of Genetic Information.** Effective immediately, Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of the HIPAA rules.

g. **Penalties for Noncompliance.** Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the HIPAA Rules, to the extent provided by the HITECH Act and the HIPAA Rules.

3. ***Compliance with Electronic Transactions Rule*****.** If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which HHS has established standards, Business Associate will comply, and will require any Subcontractor it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule and of any operating rules adopted by HHS with respect to Transactions.

4. ***Individual Rights.***

a. **Access.** Business Associate will, within twenty-nine calendar days following Covered Entity's request, make available to Covered Entity (or, at Covered Entity's written direction, to an individual or the individual's designee) for inspection and copying Protected Health Information about the individual that is in a Designated Record Set in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 CFR § 164.524. If Covered Entity requests an electronic copy of Protected Health

Information that is maintained electronically in a Designated Record Set in the Business Associate's custody or control, Business Associate will provide an electronic copy in the form and format specified by the Covered Entity if it is readily producible in such format; if it is not readily producible in such format, Business Associate will work with Covered Entity to determine an alternative form and format that will enable Covered Entity to meet its electronic access obligations under 45 CFR § 164.524.

b. **Amendment.** Business Associate will, upon receipt of written notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of an individual's Protected Health Information that is in a Designated Record Set in the custody or control of the Business Associate, so that Covered Entity may meet its amendment obligations under 45 CFR § 164.526.

c. **Disclosure Accounting.** To allow Covered Entity to meet its obligations to account for disclosures of Protected Health Information under 45 CFR § 164.528:

(i) Disclosures Subject to Accounting. Business Associate will record the information specified below ("Disclosure Information") for each disclosure of Protected Health Information, not excepted from disclosure accounting as specified below, that Business Associate makes to Covered Entity or to a third party.

(ii) Disclosures Not Subject to Accounting. Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of Protected Health Information if Covered Entity need not account for such disclosures under the HIPAA Rules.

(iii) Disclosure Information. With respect to any disclosure by Business Associate of Protected Health Information that is not excepted from disclosure accounting under the HIPAA Rules, Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:

(A) Disclosure Information Generally. Except for repetitive disclosures of Protected Health Information as specified below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which Business Associate made the disclosure, (iii) a brief description of the Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure.

(B) Disclosure Information for Repetitive Disclosures. For repetitive disclosures of Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified above for each accountable disclosure, or (i) the Disclosure Information specified above for the first of the repetitive accountable

disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.

(iv) Availability of Disclosure Information. Business Associate will maintain the Disclosure Information for at least six years following the date of the accountable disclosure to which the Disclosure Information relates. Business Associate will make the Disclosure Information available to Covered Entity fifty-nine calendar days following Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting.

d. **Restriction Agreements and Confidential Communications.** Covered Entity shall notify Business Associate of any limitations in the notice of privacy practices of Covered Entity under 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information. Business Associate will comply with any notice from Covered Entity to (1) restrict use or disclosure of Protected Health Information pursuant to 45 CFR § 164.522(a), or (2) provide for confidential communications of Protected Health Information pursuant to 45 CFR § 164.522(b), provided that Covered Entity notifies Business Associate in writing of the restriction or confidential communications obligations that Business Associate must follow. Covered Entity will promptly notify Business Associate in writing of the termination of any such restriction or confidential communications requirement and, with respect to termination of any such restriction, instruct Business Associate whether any of the Protected Health Information will remain subject to the terms of the restriction agreement.

5. *Breaches and Security Incidents*.

a. **Reporting.**

(i) Impermissible Use or Disclosure**.** Business Associate will report to Covered Entity any use or disclosure of Protected Health Information not permitted by this Agreement not more than fifty-nine calendar days after Business Associate discovers such non-permitted use or disclosure.

(ii) Breach of Unsecured Protected Health Information**.** Business Associate will report to Covered Entity any potential Breach of Unsecured Protected Health Information not more than fifty-nine calendar days after discovery of such potential Breach. Business Associate will treat a potential Breach as being discovered in accordance with 45 CFR § 164.410. Business Associate will make the report to Covered Entity's Privacy Officer. If a delay is requested by a law-enforcement official in accordance with 45 CFR § 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will include at least the following, provided that absence of any information will not be cause for Business Associate to delay the report:

(A) Identify the nature of the Breach, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

(B) Identify the types of Protected Health Information that were involved in the Breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, or other information were involved);

(C) Identify who made the non-permitted use or disclosure and who received the non- permitted disclosure;

(D) Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects, and to protect against any further Breaches;

(E) Identify what steps the individuals who were subject to a Breach should take to protect themselves;

(F) Provide such other information, including a written report and risk assessment under 45 CFR § 164.402, as Covered Entity may reasonably request.

(iii) Security Incidents. Business Associate will report to Covered Entity any Security Incident of which Business Associate becomes aware. Business Associate will make this report once per month, except if any such Security Incident resulted in a disclosure not permitted by this Agreement or Breach of Unsecured Protected Health Information, Business Associate will make the report in accordance with the provisions set forth above.

b. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect known to the Business Associate resulting from a use or disclosure in violation of this Agreement.

6. ***Term and Termination.***

a. **Term.** This Agreement shall be effective as the Effective Date, and shall remain in effect until the Service Agreement terminates.

b. **Right to Terminate for Cause.** Notwithstanding “a” above, Covered Entity may terminate this Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement, and after written notice to Business Associate of the breach, Business Associate has failed to cure the breach within thirty calendar days after receipt of the notice. Any such termination will be effective immediately or at such other date specified in Covered Entity’s notice of termination.

c. **Treatment of Protected Health Information on Termination.**

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(i) Return or Destruction of Covered Entity's Protected Health Information Is Feasible. Upon termination of this Agreement, Business Associate will, if feasible, return to Covered Entity or destroy all Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of the Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of any Subcontractors of Business Associate. Further, Business Associate shall require any such Subcontractor to certify to Business Associate that it has returned or destroyed all such information which could be returned or destroyed. Business Associate will complete these obligations as promptly as possible, but not later than thirty calendar days following the effective date of the termination of this Agreement.

(ii) Procedure When Return or Destruction Is Not Feasible. Business Associate will identify any Protected Health Information, including any Protected Health Information that Business Associate has disclosed to Subcontractors, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. Business Associate will complete these obligations as promptly as possible, but not later than thirty calendar days following the effective date of the termination or other conclusion of Agreement.

(iii) Continuing Privacy and Security Obligation. Business Associate's obligation to protect the privacy and safeguard the security of Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

7. *General Provisions.*

a. **Definitions.** All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations, and other official government guidance.

b. **Inspection of Internal Practices, Books, and Records.** Business Associate will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information available to Covered Entity and to HHS to determine compliance with the HIPAA Rules.

c. **Amendment to Agreement.** This Agreement may be amended only by a written instrument signed by the parties. In case of a change in applicable law, the parties agree to negotiate in good faith to adopt such amendments as are necessary to comply with the change in law.

d. **No Third-Party Beneficiaries.** Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.

e. **Interpretation.** Any ambiguity in the Agreement shall be resolved to permit Covered Entity and Business Associate to comply with the applicable requirements under the HIPAA Rules.

f. **Severability.** The invalidity or unenforceability of any provisions of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect.

g. **Construction and Interpretation.** The section headings contained in this Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this Agreement. This Agreement has been negotiated by the parties at arm's-length and each of them has had an opportunity to modify the language of the Agreement. Accordingly, the Agreement shall be treated as having been drafted equally by the parties, and the language shall be construed as a whole and according to its fair meaning. Any presumption or principle that the language is to be construed against any party shall not apply. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

h. **Notices.** All notices and communications required by this Agreement shall be in writing. Such notices and communications shall be given in one of the following forms: (i) by delivery in person, (ii) by a nationally-recognized, next-day courier service, (iii) by first-class, registered or certified mail, postage prepaid; or (iv) by electronic mail to the address that each party specifies in writing.

i. **Entire Agreement.** This Agreement constitutes the entire agreement between the parties with respect to its subject matter and constitutes and supersedes all prior agreements, representations and understandings of the parties, written or oral, with regard to this same subject matter.

□ **IN WITNESS WHEREOF,** the parties have entered into this Agreement as of the Effective Date.

COVERED ENTITY

By:

Title: Associate Director of HR - HRIS & Benefits

BUSINESS ASSOCIATE

By:

Title: President