

**ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
AS AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2010**

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**ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN**

As Amended and Restated Effective January 1, 2010

ARTICLE I. Introduction

1.1 Establishment of Plan

The Arizona Board of Regents, a body corporate created by the Arizona Constitution with powers enumerated in Article 2, Chapter 13, Title 15, Arizona Revised Statutes (A.R.S. sections 15-1621 through 15-1637) (at times referred to as the “**Board**” or the “**Employer**,” as the context requires), adopted The Arizona Board of Regents Health and Dependent Care Cafeteria Plan, effective as of April 1, 1991 (the “**1991 Plan**”), pursuant to Code § 125, in order to establish a “cafeteria plan” to provide Eligible Employees certain welfare and other benefits. The Employer hereby amends and restates the 1991 Plan by adopting this plan known as the “Arizona Board of Regents Health and Dependent Care Cafeteria Plan” (“**Plan**”), effective January 1, 2010 (“**the Effective Date**”). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions under a Medical Insurance Plan and Group Term Life Insurance Plan on a pre-tax Salary Reduction basis, to contribute to an account on a pre-tax Salary Reduction basis for reimbursement of certain Medical Care Expenses (Health FSA Account) and to contribute to an account on a pre-tax Salary Reduction basis for reimbursement of certain Dependent Care Expenses (DCAP Account).

1.2 Legal Status

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

The Health FSA Component is intended to qualify as a “self-insured medical reimbursement plan” under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 105(b). The DCAP Component is intended to qualify as a “dependent care assistance program” under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 129(a).

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

ARTICLE II. Definitions

2.1 Definitions

“**Account(s)**” means the Health FSA Accounts described in Section 7.5 and the DCAP Accounts described in Section 9.5.

“**A.R.S.**” means the Arizona Revised Statutes, as constituted from time-to-time.

“**Board**” means the Arizona Board of Regents.

“**Benefits**” means the Premium Payment Benefits, Health FSA Benefits and the DCAP Benefits offered under the Plan.

“**Benefit Package Option**” means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan (such as an indemnity option, an EPO option, an HMO option, or a PPO option under an accident or health plan) or an option for coverage under a group term life insurance plan.

“**Change in Status**” has the meaning described in Section 12.3.

“**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Contributions**” means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits and Section 9.2 for DCAP Benefits.

“**Committee**” means the Benefits Committee appointed by the Employer, which can consist of an individual Employee.

“**Compensation**” means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan, (b) any salary reduction election under any other cafeteria plan, and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 403(b) or 457(b) plan or arrangement. Thus, “Compensation” generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

“**DCAP**” means dependent care assistance program.

“**DCAP Account**” means the account described in Section 9.5.

“DCAP Benefits” has the meaning described in Section 9.1.

“DCAP Component” means the Component of this Plan described in Article IX.

“Dependent” means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component, (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; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 9.3(c). Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “Dependent.”

“Dependent Care Expenses” has the meaning described in Section 9.3.

“Earned Income” means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

“Effective Date” of this Plan, as amended and restated, means January 1, 2010.

“Election Form/Salary Reduction Agreement” means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

“Eligible Employee” means an Employee eligible to participate in this Plan, as provided in Section 3.1.

“Employee” means: (a) any member of the faculty, administrative officers and academic professionals of the institutions under the jurisdiction of the Board; (b) the staff of the Board; and (c) any other person employed by the institutions under the jurisdiction of the Board who are approved by the Board to be treated as Employees hereunder and eligible to participate herein, including Employees who are on a leave of absence with pay. The term “Employee” does not include: (d) a person employed for less than 20 hours per week; and (e) a temporary employee whose employment is for a term of not more than six months, but if the employment continues beyond the period of six successive months, the person shall be treated as an Employee as of the beginning of the next successive payroll period.

“Employer” means the Board and the employing unit(s) under the jurisdiction of the Board who employ Employees who are eligible to participate in this Plan, namely, Arizona State University, the University of Arizona and Northern Arizona University (at times referred to as the **“Universities”**).

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

“EPO” means a self-insured exclusive provider organization.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended. Because the Plan is a “governmental plan” as defined in Section 3(32) of ERISA, the Plan is not subject to ERISA.

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

“General-Purpose Health FSA Option” has the meaning described in Section 7.3(b).

“Group Term Life Insurance Benefits” means the Employee’s Group Term Life Insurance Plan coverage for purposes of this Plan.

“Group Term Life Insurance Plan” means a policy of life insurance either (1) maintained by an Employer or (2) administered by the United States Federal Government through which certain Employees of the University of Arizona are eligible to elect benefits that meets the following conditions and which is approved by the Employer as a policy to be included for providing benefits under this Plan:

(a) The policy must provide a general death benefit that is excluded from gross income under Code § 101(a);

(b) The policy must be provided to a group of Employees;

(c) The policy must be carried directly or indirectly by an Employer;

(d) The amount of insurance provided to each Employee must be computed under a formula that precludes individual selection; and

(e) The policy must provide no permanent benefits or insurance on the life of anyone other than an Employee (whether includible or excludible from the Employee’s gross income).

In all cases, the policy must qualify as a group term life insurance policy as defined in Code § 79 and the Treasury Regulations issued thereunder.

“Health FSA” means health flexible spending arrangement, which consists of two options: the General-Purpose Health FSA Option; and the Limited (Vision/Dental/Preventive Care) Health FSA Option.

“Health FSA Account” means the account described in Section 7.5.

“Health FSA Benefits” has the meaning described in Section 7.1.

“Health FSA Component” means the Component of this Plan described in Article VII.

“Health Reimbursement Arrangement” or **“HRA”** means a health reimbursement arrangement as defined in IRS Notice 2002-45. The Employer does not currently offer an HRA.

“Health Savings Account” or **“HSA”** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. The Employer does not currently offer an HSA under this Plan, but, as provided in Article VIII, may offer an HSA arrangement under another plan in which the Employer participates.

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

“HMO” means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

“Limited (Vision/Dental/Preventive Care) Health FSA Option” has the meaning described in Section 7.3(b).

“Medical Care Expenses” has the meaning defined in Section 7.3, except in no case shall Medical Care Expenses include expenses described on Appendix A to this Plan.

“Medical Insurance Benefits” means the Employee’s Medical Insurance Plan coverage for purposes of this Plan.

“Medical Insurance Plan” means the plan(s) for Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical (including EPO, HMO and PPO options), dental, optical, and dismemberment benefits under insurance and self-insured programs either (1) maintained by an Employer or (2) administered by the United States Federal Government and under which certain Employees of the University of Arizona are eligible to elect benefits. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

“Open Enrollment Period” with respect to a Plan Year means the period designated by the Administrator in the year preceding the Plan Year.

“Participant” means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Medical Insurance Benefits, Group Term Life Insurance Benefits, Health FSA Benefits, DCAP Benefits and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and who have not elected any such Benefits.

“Period of Coverage” means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

“Plan” means the Arizona Board of Regents Health and Dependent Care Cafeteria Plan as set forth herein and as amended from time to time.

“Plan Administrator” means the Board, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

“Plan Year” means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

“PPO” means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

“Premium Payment Benefits” means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

“Premium Payment Component” means the Component of this Plan described in Article VI.

“QMCSO” means a qualified medical child support order, as defined in ERISA § 609(a).

“Qualifying Dependent Care Services” has the meaning described in Section 9.3.

“Qualifying Individual” has the meaning described in Section 9.3.

“Qualified Reservist Distribution” means a distribution to a reservist as described in Section 7.9.

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

“Spouse” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCAP Component the term “Spouse” shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

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

“University” or **“Universities”** refers to Arizona State University, the University of Arizona and Northern Arizona University.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan (including the Premium Payment Component, Health FSA Component and the DCAP Component) if the individual satisfies all of the following: (a) is an Employee; and (b) is working 20 or more hours per week. As prescribed by an Employer for its group of Employees, an Employee will commence Participation in the Plan on either: (y) the first day of the first payroll period following the Employee’s enrollment within 31 days of the Employee’s Employment Commencement Date; or (z) the first day of the calendar month following the Employee’s enrollment within 30 days of the Employee’s Employment Commencement Date. Eligibility for Premium Payment Benefits shall also be subject to the additional requirement, if any, specified in the Medical Insurance Plan or Group Term Life Insurance Plan. Once an Employee has met the Plan’s eligibility requirements, the Employee may elect coverage effective on the date specified in the second sentence in this Section 3.1 or, for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

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

- the termination of this Plan; or

- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits, Section 7.8 for Health FSA Benefits, and Section 9.8 for DCAP Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits or Group Term Life Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan or Group Term Life Insurance Plan. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan or Group Term Life Insurance Plan, as the case may be, is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee will recommence participation in the Plan on the date specified in Section 3.1.

3.4 FMLA Leaves of Absence

- (a) *Health Benefits.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions, if any.

An Employer may require participants to continue all Medical Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the

method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways if allowed by an Employer:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If a Participant's Medical Insurance Benefits and Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits or Health FSA Benefits, as the case may be, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-

period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

- (b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as Group Term Life Insurance Benefits and DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Employer and the Participant or as the Employer otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Employer. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 12.4(d) will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits effective on the date specified in Section 3.1. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan or Group Term Life Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan or Group Term Life Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Employer shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Employer on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year.

If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

- (a) Premium Payment Benefits, as described in Article VI.
- (b) Health FSA Benefits, as described in Article VII. The Health FSA election may be for:
 - A General-Purpose Health FSA Option; or
 - If the Participant has elected to participate in an HSA offered by an Employer under an HSA program outside this Plan, a Limited (Vision/Dental/Preventive Care) Health FSA Option.
- (c) DCAP Benefits, as described in Article IX.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* For Participants who elect Medical Insurance Benefits or Group Term Life Insurance Benefits described in Article VI, the Employer will contribute a portion, if any, of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. There are no Employer contributions for Health FSA Benefits or DCAP Benefits.
- (b) *Participant Contributions.* Participants who elect any of the Medical Insurance Benefits or Group Term Life Insurance Benefits described in Article VI, Health FSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

- (a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits and Section 9.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage or the number of pay periods in the Period of Coverage counting only 2 pay periods for each calendar month; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component or DCAP Component to the extent permitted under Section 12.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.4, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).
- (b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.
- (c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date

Salary Reductions exceed or are less than the Participant's required Contributions for the coverage due to a mistake or administrative error, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policies. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, (except for Premium Payment Benefits paid as provided in the applicable insurance policies) it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as Contributions described under Section 7.4(b) for Health FSA Benefits and Section 9.4(b) for DCAP Benefits.

ARTICLE VI. Premium Payment Component

6.1 Benefits

The only Medical Insurance Benefits that are offered under the Premium Payment Component are benefits under the Medical Insurance Plan, providing major medical (including EPO, HMO and PPO options), dental, optical and disability benefits. The only Group Term Life Insurance Benefits that are offered under the Premium Payment Component are benefits under the Group Term Life Insurance Plan, providing group term life insurance benefits. Notwithstanding any other provision in this Plan, the Medical Insurance Benefits and Group Term Life Insurance Benefits are subject to the terms and conditions of the Medical Insurance Plan and Group Term Life Insurance Plan, as the case may be, and no changes can be made with respect to such Medical Insurance Benefits or Group Term Life Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical Insurance Benefits or Group Term Life Insurance Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and make no pretax Salary Reduction contributions to the Premium Payment Component of this Plan. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan

Medical Insurance Benefits will be provided by the Medical Insurance Plan, not this Plan. The types and amounts of Medical Insurance Benefits (here, major medical insurance), the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plan are set forth in the Medical Insurance Plan. All claims to receive benefits under the Medical Insurance Plan shall be subject to and governed by the terms and conditions of the Medical Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

7.3 Eligible Medical Care Expenses for Health FSA

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

- (a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.
- (b) *Medical Care Expenses.* “Medical Care Expenses” will vary depending on which Health FSA coverage option the Participant has elected.
 - *General-Purpose Health FSA Option.* For purposes of this Option, “Medical Care Expenses” means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d); provided, however, that this term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.
 - *Limited (Vision/Dental/Preventive Care) Health FSA Option.* For purposes of this Option, “Medical Care Expenses” means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d); provided, however, that such expense is for vision care, dental care, or preventive care (as defined in Code § 223(c)) only, and provided that this term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

7.4 Maximum and Minimum Benefits for Health FSA

- (a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.
- (b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$5,000.00, subject to Section 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.
- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 12.4, then there will be no proration rule; i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.
- (d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII (other than under Section 12.4(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 12.4(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

- (e) *Monthly Limits on Reimbursing OTC Drugs.* Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII, including that it is for medical care under Code § 213(d)); stockpiling is not permitted.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

- (a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.
- (c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-It-or-Lose-It Rule

- (a) *Use-It-or-Lose-It Rule.* If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- (b) *Use of Forfeitures.* All forfeitures under this Plan shall be retained by the Employer and the Participants shall have no claim thereto. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit

checks) after the Employer has made reasonable attempts to contact the Participant shall be remitted to the State of Arizona as unclaimed property.

7.7 Reimbursement Claims Procedure for Health FSA

- (a) *Timing.* Within 30 days after receipt by the Employer (or such third-party administrator who may be administering this Plan on behalf of the Plan Administrator or Employer(s)) of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Employer approves the claim), or the Employer will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Employer, including in cases where a reimbursement claim is incomplete. The Employer will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Employer in such form as the Employer may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:
- the person(s) on whose behalf Medical Care Expenses have been incurred;
 - the nature and date of the Expenses so incurred;
 - the amount of the requested reimbursement;
 - a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
 - other such details about the expenses that may be requested by the Employer in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Employer may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43 or other IRS guidance.

- (c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.
- (d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within the period set forth in Section 7.7(b).

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

7.9 Coordination of Benefits

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

7.10 Qualified Reservist Distributions

Notwithstanding any other provision of the Plan to the contrary, a Participant who meets each of the following requirements may elect to receive a distribution of certain funds from his or her account in the Health FSA Component for a Plan Year as a Qualified Reservist Distribution:

- The Participant's contributions to his or her Health FSA Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution exceed the reimbursements he or she has received from his or her Health FSA Account for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- The Participant has provided the Employer (or its designee) with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- The Participant is ordered or called to active military duty on or after April 1, 2009, or his or her period of active duty begins before April 1, 2009 and continues on or after that date.
- During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant delivers a written election to the Employer (or its designee) in such form as the Employer may prescribe, requesting a Qualified Reservist Distribution.

The Employer will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. Requests for Qualified Reservist Distributions that are approved by the Employer shall be paid within a reasonable time, not to exceed 60 days after the date of the Participant's request.

The amount of any Qualified Reservist Distribution made under this provision shall be equal to the Participant's contributions to his or her Health FSA Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution, minus the reimbursements he or she has received from his or her Health FSA Account for the Plan Year as of that date. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Medical Care Expenses have been

incurred. Any portion of the distribution that is not a reimbursement for substantiated Medical Care Expenses will be included in the Participant's gross income and wages.

A Participant who has requested a Qualified Reservist Distribution shall forfeit the right to receive reimbursements for Medical Care Expenses incurred during the Plan Year and on or after the date of the distribution request. However, such a Participant may claim reimbursement for Medical Care Expenses incurred during the Plan Year (or other Period of Coverage, if applicable) and before the date of the distribution request, even if such claims are submitted after the date of his or her distribution, so long as the total dollar amount of such claims does not exceed the amount of the Participant's election under the Health FSA Component for the Plan Year, less the sum of his or her Qualified Reservist Distribution under this provision and the reimbursements he or she has received from his or her Health FSA Account for the Plan Year.

ARTICLE VIII. HSA Benefits

8.1 HSA Benefits Provided Through Other Plans

An Employer may maintain a Health Savings Account program described under Code § 223 outside this Plan to provide HSA benefits to its Employees, which such HSA program shall be governed by the terms of the documents establishing such program.

8.2 Health FSA Benefits Coordinated With HSA Benefits

The Limited (Vision/Dental/Preventive Care) Health FSA Option described in Section 7.3(b) is offered under this Plan to allow a Participant to elect such Option and also participate in a HSA program that may be offered the Employer.

ARTICLE IX. DCAP Component

9.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

9.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b). (For example, if the maximum \$5,000 annual benefit amount is elected, then the annual Contribution amount is also \$5,000.)

9.3 Eligible Dependent Care Expenses

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

- (a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).
- (b) *Dependent Care Expenses.* “Dependent Care Expenses” are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse’s DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.
- (c) *Qualifying Individual.* “Qualifying Individual” means:
 - a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant’s qualifying child as defined in Code § 152(a)(1);
 - a tax dependent of the Participant as defined in Code § 152 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; or
 - 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.

Notwithstanding the foregoing, 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)(3)(A)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

- (d) *Qualifying Dependent Care Services.* “Qualifying Dependent Care Services” means the following: services that both (1) relate to the care of a Qualifying

Individual that enable the Participant to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed –

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

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

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse; or
- a Participant's child (as defined in Code § 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred.

9.4 Maximum and Minimum Benefits for DCAP

- (a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article IX have been satisfied.
- (b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be \$5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is

made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of \$250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of \$500 per month); or
- either \$5,000 or \$2,500 for the calendar year, as applicable:

(1) \$5,000 for the calendar year if one of the following applies:

- the Participant is married and files a joint federal income tax return;
- the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or
- the Participant is single or is the head of the household for federal income tax purposes; or

(2) \$2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 12.4, then there

will be no proration rule; i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

- (d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

9.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

- (a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount Is Based on Credited Amount.* As described in Section 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

9.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be retained by the Employer and the Participant shall have no claim thereto. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) after the Employer has made reasonable attempts to contact the Participant shall be remitted to the State of Arizona as unclaimed property.

9.7 Reimbursement Claims Procedure for DCAP

- (a) *Timing.* Within 30 days after receipt by the Employer (or such third-party administrator who may be administering this Plan on behalf of the Plan Administrator or Employer(s)) of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Employer approves the claim), or the Employer will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Employer, including in cases where a reimbursement claim is incomplete. The Employer will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Employer in such form as the Employer may prescribe, by no later than the April 30 following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:
 - the person(s) on whose behalf Dependent Care Expenses have been incurred;
 - the nature and date of the Expenses so incurred;
 - the amount of the requested reimbursement;
 - the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
 - a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and
- other such details about the expenses that may be requested by the Employer in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

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

- (c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

9.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible, with one exception: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim within the period set forth in Section 9.7(b)..

9.9 Report to DCAP Participants

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

ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA 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 HIPAA definition of PHI applies for purposes of this Article X:

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 Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"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 at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims

processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions 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 § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

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

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that the adequate separation between the Health FSA and the Employer (i.e., the “firewall”), required in 45 CFR § 504(f)(2)(iii), is satisfied.

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 Health FSA, 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 agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Plan Administrator shall allow the following persons access to PHI: the Executive Director of the Board; the Human Resource Directors of the Universities; such staff of the Board or the Universities designated by the Executive Director or Human Resource Directors identified above who need access to PHI in order to perform administrative functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals); and any other Employee who needs access to PHI in order to perform Plan administration functions. No other persons shall have access to PHI. These specified employees (or classes of 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 Health FSA. 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 employee discipline and termination procedures. The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

ARTICLE XI. [Reserved]

ARTICLE XII. Irrevocability of Elections; Exceptions

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant’s election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless

an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options (including the various Health FSA Options).

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

- (a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 12.4(d) through 12.4(i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.
- (b) *Effective Date of New Election.* Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only. As specified by the Employer, the election changes for the Employer's group of Employees will become effective as of the first day of the calendar month following the date the election change was filed or the first day of the first payroll period following the date the election change was filed; provided that, as determined by the Employer, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later.
- (c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 9.4 respectively.

12.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 12.4, including a Change in Status, for the applicable Component. “Change in Status” means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- (a) *Legal Marital Status.* A change in a Participant’s legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;
- (b) *Number of Dependents.* Events that change a Participant’s number of Dependents, including birth, death, adoption, and placement for adoption;
- (c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence (other than mandatory furlough days imposed on the Participant by his or her Employer from time-to-time); (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual’s status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;
- (d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and
- (e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

12.4 Events Permitting Exception to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

- (a) *Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

- (b) *Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.
- (c) *Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.
- (d) *Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below).* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 12.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

As permitted in the preceding paragraph, election changes may be made to increase, reduce or cancel Health FSA coverage during a Period of Coverage. Notwithstanding the foregoing, such reduction or cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

- (1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar

health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

- (2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Employer may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Employer has reason to believe that the Participant's certification is incorrect.
- (3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.
- (e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:
 - a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days). For purposes of this Section 12.4(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

- (f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
- (g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her

Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

- (h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 12.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an EPO, HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.
- (1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Employer, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Employer, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.
- (2) *Significant Cost Increases.* If the Employer determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.
- (3) *Significant Cost Decreases.* If the Employer determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance

Plan) significantly decreases during a Period of Coverage, then the Employer may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (such as an HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance,

- (4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above “Change in Cost” provisions (Sections 12.4(h)(1) through 12.4(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a “relative” of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).
- (i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).* The definition of “similar coverage” under Section 12.4(h) applies also to this Section 12.4(i).
- (1) *Significant Curtailment.* If coverage is “significantly curtailed” (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a “Loss of Coverage” (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Employer in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is “significant,” and whether a Loss of Coverage has occurred.
 - (a) *Significant Curtailment Without Loss of Coverage.* If the Employer determines that a Participant’s coverage under a Benefit Package Option under this Plan (or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides

similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

- (b) *Significant Curtailment With a Loss of Coverage.* If the Employer determines that a Participant’s Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.
- (c) *Definition of Loss of Coverage.* For purposes of this Section 12.4(i)(1), a “Loss of Coverage” means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Employer, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:
- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
 - a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
 - any other similar fundamental loss of coverage.
- (2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Employer may permit the following election changes: (a) Participants who

are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

- (3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).
- (4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.
- (5) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes

available to take care of the child at no charge, then the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section 12.4 must do so in accordance with the procedures described in Section 12.2.

12.5 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the participant plan information for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Medical and Group Term Life Insurance Benefits

Claims and reimbursement for Medical Insurance Benefits and Group Term Life Insurance Benefits shall be administered in accordance with the claims procedures for the Medical Insurance Benefits and Group Term Life Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Medical Insurance Plan and Group Life Insurance Plan.

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance

with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- (f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including third-party administrators, legal counsel and benefit consultants;
- (h) to delegate to an Employer such powers and duties as may be necessary to administer this Plan as specifically provided or contemplated herein;

- (i) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (j) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (k) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Plan Administrator and an Employer may employ the services of such persons as they may deem necessary or desirable in connection with the operation of the Plan.

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator and an Employer shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.7 Effect of Mistake

In the event of a mistake 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 Plan Administrator shall, to the extent that it deems

administratively possible and otherwise permissible under Code § 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 entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are paid by any one or more of the following: (1) forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 9.6 with respect to DCAP Benefits; (2) assessments against the Participants' Health FSA and DCAP Accounts; and (3) the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Board may amend or terminate all or any part of this Plan at any time for any reason and any such amendment or termination will automatically apply to all the Employers.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Arizona, to the extent not superseded by the Code or any other federal law. In particular and without limitation, the following provisions of Arizona law shall apply:

- (a) In administering this Plan, the Board and Employers will comply with all applicable state and federal laws, rules, regulations and executive orders governing equal employment opportunity, immigration, nondiscrimination, including the Americans with Disabilities Act, and affirmative action.
- (b) As provided in A.R.S. section 38-511, this Plan or any of the administrative contracts hereunder may be canceled if any person significantly involved in initiating, negotiating, securing, drafting or creating this Plan or any contract on behalf of the Board of an Employer is an employee, consultant, or agent of any other party to such contract.

- (c) The Board, the Employers and any other party providing services under this Plan are given notice of and are bound by the arbitration provisions of A.R.S. sections 12-1518 and 12-133.
- (d) Pursuant to A.R.S. section 35-397, any person providing services under this Plan certifies that it does not have a scrutinized business operation in either Sudan or Iran.
- (e) As required by A.R.S. section 41-4401, the Board or any Employer is prohibited after September 30, 2008 from awarding a contract to any service or construction contractor who fails, or whose subcontractors fail, to comply with A.R.S. section 23-214-A. Any person to whom a contract may be awarded under this Plan ("Contractor") warrants that it complies fully with all federal immigration laws and regulations that relate to its employees, that it shall verify, through the employment verification pilot program as jointly administered by the U.S. Department of Homeland Security and the Social Security Administration or any of its successor programs, the employment eligibility of each employee hired after December 31, 2007, and that it shall require its subcontractors and sub-subcontractors to provide the same warranties to the Contractor. The Contractor acknowledges that a breach of this warranty by the Contractor or by any subcontractor or sub-subcontractor providing services under this Plan shall be deemed a material breach of this Plan, and is grounds for penalties, including termination by the Board of an Employer of any contracts whereby the Contractor provides services hereunder. The Board and Employers retain the right to inspect the records of any Contractor, subcontractor and sub-subcontractor employee who performs services under this Plan, and to conduct random verification of the employment records of the Contractor and any subcontractor or sub-subcontractor who provides services under this Plan, to ensure that the Contractor and each subcontractor and sub-subcontractor is complying with the warranties set forth above. The Contractor shall be responsible for all costs associated with compliance with this requirement.
- (f) To the extent required by A.R.S. section 35-214, the Employers and anyone providing services under this Plan agree to retain all records relating to the Plan and the administration thereof and to make those records available at all reasonable times for inspection and audit by the Arizona Auditor General or the Board during the terms of this agreement and for five years after its completion or termination. The records will be delivered to the Board office or another location designated by the Board with reasonable notice to the parties providing such records.

15.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered

accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Employer if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

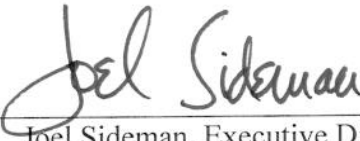
In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Arizona Board of Regents Health and Dependent Care Cafeteria Plan, the Board has caused this Plan to be executed in its name and on its behalf and on behalf of all Employers, on this 7 day of DECEMBER, 2009.

ARIZONA BOARD OF REGENTS

By 
Joel Sideman, Executive Director

Appendix A

Exclusions – Medical Expenses That Are Not Reimbursable From the Health FSA

Exclusions: *The following expenses are not reimbursable from the Health FSA, even if they meet the definition of “medical care” under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs:*

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.

**FIRST AMENDMENT TO
THE ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan; and

WHEREAS, the Board maintains another cafeteria plan known as "The Arizona Board of Regents Cafeteria Plan" (hereafter, the "Other Cafeteria Plan"), which also provides certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is adopting amendments to the Other Cafeteria Plan to change the Plan Year of the Other Cafeteria Plan to coincide with the Plan Year of this Plan ending December 31 of each year; and

WHEREAS, the Board has determined that it is administratively efficient to terminate the Other Cafeteria Plan, effective December 31, 2010, and thereafter provide all cafeteria plan benefits under this Plan; and

WHEREAS, the Board has determined that an amendment to this Plan is required to change the name of the Plan and to confirm that, commencing with the Plan Year beginning January 1, 2011, all cafeteria plan benefits provided under the Other Cafeteria Plan will be provided under this Plan; and

WHEREAS, the Board has determined that additional amendments to the Plan are required to comply with various laws that take effect during and after the Plan Year commencing January 1, 2010, including the provisions of Michelle's Law (H.R. 2851), the Mental Health Parity and Addiction Equity Act of 2008, and Genetic Information Nondiscrimination Act of 2008 ("GINA"); and

WHEREAS, the Board has determined that additional amendments to the Plan are required to incorporate certain changes required by the Patient Protection and Affordable Care Act of 2010 by (a) permitting reimbursement for health and medical expenses for the children of Participants who have not attained age 27 by the last day of a Plan Year, (b) permitting Participants to pay for medical insurance premiums for coverage of their children who have not attained age 26 by the last day of a Plan Year, and (c) prohibiting reimbursement of certain over-the-counter medicines or drugs; and

WHEREAS, the Board has determined that these amendments are required to assure the Plan's successful operation and administration;

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. The definition of "Plan" contained in Section 2.1 of the Plan, is hereby amended in its entirety, effective January 1, 2011, to read as follows:

"Plan" means The Arizona Board of Regents Premium Payment, Health and Dependent Care Cafeteria Plan as set forth herein and as amended from time to time."

2. The definition of "Medical Insurance Plan" contained in Section 2.1 of the Plan, is hereby amended in its entirety, effective January 1, 2011, to read as follows:

"Medical Insurance Plan" means the plan(s) for Employees (and for their Spouses or Dependents or children (as defined in Code §

152(f)(1)) who have not attained age 26 by the end of the Plan Year who may be eligible under the terms of such Medical Insurance Plan), providing major medical (including EPO, HMO and PPO options), dental, optical, and dismemberment benefits under insurance and self-insured programs either (1) maintained by an Employer or (2) administered by the United States Federal Government and under which certain Employees of the University of Arizona are eligible to elect benefits. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan."

3. Effective January 1, 2011, the Premium Payment Component contained in Article VI of the Plan, shall include all major medical (including EPO, HMO and PPO Options) dental, optical, dismemberment benefits and disability (pre-tax contributions only) benefits previously provided by the Employer under the Other Cafeteria Plan, which the Employer elects to continue to provide under the terms of this Plan.

4. Section 7.3(b), "Medical Care Expenses," is hereby amended in its entirety, effective for Medical Care Expenses incurred on or after March 30, 2010, to read as follows:

"(b) *Medical Care Expenses.* 'Medical Care Expenses' will vary depending on which Health FSA coverage option the Participant has elected.

- *General-Purpose Health FSA Option.* For purposes of this Option, 'Medical Care Expenses' means expenses incurred by a Participant or his or her Spouse or Dependents or his child (as defined in Code § 152(f)(1)) who has not attained age 27 by the end of the Plan Year for medical care, as defined in Code § 213(d); provided, however, that this term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

- *Limited (Vision/Dental/Preventive Care) Health FSA Option.* For purposes of this Option, 'Medical Care Expenses' means expenses incurred by a Participant or his or her Spouse or Dependents or his child (as defined in Code § 152(f)(1)) who has not attained age 27 by the end of the Plan Year for medical care, as defined in Code § 213(d); provided, however, that such expense is for vision care, dental care, or preventive care (as defined in Code § 223(c)) only, and provided that this term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII."

5. Appendix A, which itemizes the "Medical Care Expenses" that are excluded and not eligible for reimbursement from the Health FSA, is hereby amended, effective for any Medical Care Expenses incurred on or after January 1, 2011, by adding an additional exclusion to read as follows:

- "A medicine or drug shall be considered Medical Care Expenses only if the medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin."

6. Article XI, which was previously "Reserved," is amended in its entirety, effective January 1, 2010, to read as follows:

"Article XI. Miscellaneous Laws

11.1 Michelle's Law

The Plan's definition of "Dependent" is amended by the addition of the following:

The requirement that a Dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to a year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

Except for a student who is on a medically necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

11.2 Mental Health Parity and Addiction Equity Act of 2008

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.3 Genetic Information Nondiscrimination Act of 2008

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act."

7. In all other respects, the Plan, as amended by this First Amendment, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this First Amendment to be signed by its duly authorized representative.

DATED this 23 day of SEPTEMBER, 2010.

ARIZONA BOARD OF REGENTS

By: 
Thomas K. Anderes
President

**SECOND AMENDMENT TO
THE ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan; and

WHEREAS, the Board adopted a First Amendment to the Plan dated September 23, 2010, which, among other things, permitted Participants to pay for medical insurance premiums for coverage of their children who had not attained age 26 by the last day of the Plan Year; and

WHEREAS, the Board has been advised that the words "by the last day of the Plan Year" are unnecessary since the changes contained in the Patient Protection and Affordable Care Act of 2010 allow Participants to pay for medical insurance premiums for coverage of their children until they have attained age 26, regardless of whether they will attain age 26 by the end of the Plan Year; and

WHEREAS, the 50th Arizona Legislature in its First Regular Session, pursuant to Session Law 227, enacted new A.R.S. § 38-671, which became effective July 20, 2011; and

WHEREAS, A.R.S. § 38-671 requires, with limited exceptions, any employee hired on or after the effective date of A.R.S. § 38-671 (i.e., July 20, 2011), to complete at least ninety (90) days of employment prior to being eligible for certain employee benefits described in Article 4, Chapter 4 of Title 38 of the Arizona Revised Statutes (A.R.S. §§ 38-651, et. seq.); and

WHEREAS, this Plan is maintained by the Board pursuant to the provisions of A.R.S. § 15-1626G and is therefore not subject to the new requirements of A.R.S. § 38-671; and

WHEREAS, the Board has determined that it is in the best interest of the Employers and Employees participating under the Plan to adopt amendments to the Plan implementing a service requirement similar to that set forth in A.R.S. § 38-671; and

WHEREAS, the Board has determined that these amendments are required to assure the Plan's successful operation and administration.

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. The definition of "Medical Insurance Plan" contained in Section 2.1 of the Plan, is hereby amended in its entirety, effective January 1, 2011, to read as follows:

"Medical Insurance Plan" means the plan(s) for Employees (and for their Spouses or Dependents or children (as defined in Code § 152(f)(1)) who have not attained age 26 who may be eligible under the terms of such Medical Insurance Plan), providing major medical (including EPO, HMO and PPO options), dental, optical, and dismemberment benefits under insurance and self-insured programs either (1) maintained by an Employer or (2) administered by the United States Federal Government and under which certain Employees of the University of Arizona are eligible to elect benefits. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits,

terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan."

2. Section 3.1, Eligibility to Participate, of Article III, Eligibility and Participation, is hereby amended in its entirety, effective with respect to any Employee whose Employment Commencement Date with an Employer is on or after July 20, 2011, to read as follows:

"3.1 Eligibility to Participate

An individual is eligible to participate in this Plan (including the Premium Payment Component, Health FSA Component and the DCAP Component) if the individual satisfies all of the following: (a) is an Employee; (b) is working 20 or more hours per week; and (c) has worked regularly for an Employer (whether less than 20 hours per week or more than 20 hours per week) for at least 90 days following his or her Employment Commencement Date (an "Eligible Employee"). As prescribed by an Employer for its group of Employees, an Employee will commence Participation in the Plan after the Employee becomes an Eligible Employee and on either: (y) the first day of the first payroll period following the Employee's enrollment within 31 days of the Employee becoming an Eligible Employee; or (z) the first day of the calendar month following the Employee's enrollment within 30 days of the Employee becoming an Eligible Employee. Eligibility for Premium Payment Benefits shall also be subject to the additional requirement, if any, specified in the Medical Insurance Plan or Group Term Life Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective on the date specified in the second sentence in this Section 3.1 or, for any subsequent Plan Year, in accordance with the procedures described in Article IV."

3. Section 3.3, Participation Following Termination of Employment or Loss of Eligibility, of Article III, Eligibility and Participation, is hereby amended in its entirety, effective with respect to any Employee whose Employment Commencement Date with an Employer is on or after July 20, 2011, to read as follows:

"3.3 Participation Following Termination of Employment or Loss of Eligibility

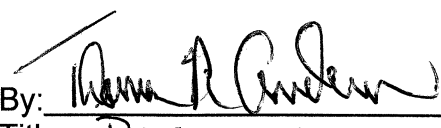
If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days but not more than 2 years following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1, except the former Participant will not be required to again complete 90 days of employment and will be an Eligible Employee immediately upon his or her Employment Commencement Date. If a former Participant is rehired more than 2 years following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1 and the Employee will once again be required to work regularly for an Employer for at least 90 days following his or her new Employment Commencement Date in order to once again be an Eligible Employee. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan or Group Term Life Insurance Plan, as the case may be, is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee will recommence participation in the Plan on the date specified in Section 3.1."

4. In all other respects, the Plan, as amended, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this Second Amendment to be signed by its duly authorized representative.

DATED this 1 day of DECEMBER, 2011.

ARIZONA BOARD OF REGENTS

By: 
Title: PRESIDENT

**THIRD AMENDMENT TO
THE ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan; and

WHEREAS, the Board wishes to limit the Participant's maximum Salary Reductions for Medical Care Expenses to not more than \$2,500.00 each Plan Year as required by Section 125(i) of the Code; and

WHEREAS, the Board has determined that this amendment is required to assure the Plan's successful operation and administration and to maintain qualification of the Plan.

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. Section 7.4(b) of Article VII of the Plan is hereby amended in its entirety, effective January 1, 2013, to read as follows:

"(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$2,500.00 (as

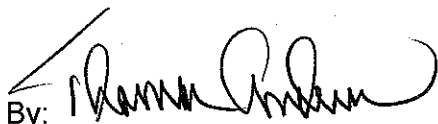
increased by an amount equal to the cost-of-living adjustment announced by the Internal Revenue Service pursuant to the provisions of Section 125(i)(2) of the Code), subject to Section 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account."

2. In all other respects, the Plan, as amended, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this Third Amendment to be signed by its duly authorized representative.

DATED this 10 day of DECEMBER, 2012.

ARIZONA BOARD OF REGENTS

By: 
Title: PRESIDENT

**FOURTH AMENDMENT TO
THE ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan; and

WHEREAS, the Board wishes to (1) eliminate the requirement to complete 90 days of employment to be eligible to participate in the Plan, (2) permit Participants to carry over \$500.00 of a Participant's unused Health FSA Account for use in the next Plan Year, and (3) clarify through what period a terminated Participant may receive reimbursement for Medical Care Expenses following termination of employment; and

WHEREAS, the Board has determined that this amendment is required to assure the Plan's successful operation and administration and to maintain qualification of the Plan.

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. Section 3.1 of Article III, Eligibility and Participation, is hereby amended in its entirety, effective September 12, 2013, to read as follows:

"3.1 Eligibility to Participate

An individual is eligible to participate in this Plan (including the Premium Payment Component, Health FSA Component and the DCAP Component) if the individual satisfies all of the following: (a) is an Employee; and (b) is working 20 or more hours per week (an "Eligible Employee"). As prescribed by an Employer for its group of Employees, an Employee will commence Participation in the Plan after the Employee becomes an Eligible Employee and on either: (y) the first day of the first payroll period following the Employee's enrollment within 31 days of the Employee becoming an Eligible Employee; or (z) the first day of the calendar month following the Employee's enrollment within 30 days of the Employee becoming an Eligible Employee. Eligibility for Premium Payment Benefits shall also be subject to the additional requirement, if any, specified in the Medical Insurance Plan or Group Term Life Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective on the date specified in the second sentence in this Section 3.1 or, for any subsequent Plan Year, in accordance with the procedures described in Article IV."

2. Section 3.3 of Article III, Eligibility and Participation, is hereby amended in its entirety, effective September 12, 2013, to read as follows:

"3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan or Group Term Life Insurance Plan, as the case may be, is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible

Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee will recommence participation in the Plan on the date specified in Section 3.1."

3. Section 7.6 of Article VII, Health FSA Component, is amended in its entirety, effective January 1, 2016, to read as follows:

"7.6 Forfeiture of Health FSA Accounts; Use-It-or-Lose-It Rule; \$500 Carryover Permitted

(a) *Use-It-or-Lose-It Rule.* Subject to Section 7.6(b), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) *Health FSA Account Carryovers Permitted.* Notwithstanding any other provision of the Plan to the contrary, amounts remaining in a Participant's Health FSA Account at the end of the period during which a Participant may submit claims for a preceding Plan Year, as provided in Section 7.7, may be used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year. The following conditions shall apply to any amounts carried over from one Plan Year to the next Plan Year:

- No more than \$500.00 of the Participant's unused Health FSA Account may be carried over for use in the next Plan Year.
- Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum annual benefit amount that a Participant may elect to receive under this Plan, as provided in Section 7.4(b), in the form of reimbursements for Medical Care Expenses incurred during the Plan Year to which the amounts were carried forward.
- Medical Care Expenses incurred in the current Plan Year will be reimbursed first from the amounts available for such reimbursement for that Plan Year. Following the close of the

period during which a Participant may submit claims for a preceding Plan Year, as provided in Section 7.7, the carryover amounts from the prior Plan Year (not exceeding \$500.00) may then be used to pay Medical Care Expenses incurred in the current Plan Year.

- If the Participant was enrolled in the General-Purpose Health FSA Option described in Section 7.3(b) in the Plan Year from which the carryover amount is carried into a subsequent Plan Year and if the Participant is enrolled in the Limited Health FSA Option described in Section 7.3(b) in the subsequent Plan Year, any amounts carried forward into the subsequent Plan Year may only be used to reimburse Medical Care Expenses incurred in the subsequent Plan Year that are eligible for reimbursement under the Limited Health FSA Option.

(c) *Use of Forfeitures.* All forfeitures under this Plan shall be retained by the Employer and the Participants shall have no claim thereto. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) after the Employer has made reasonable attempts to contact the Participant shall be remitted to the State of Arizona as unclaimed property.”

4. Section 7.8 of Article VII, Health FSA Component, is amended in its entirety, effective January 1, 2015, to read as follows:

“7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant’s Salary Reductions and election to participate will terminate. Subject to the following paragraph of this Section 7.8, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the last day of the payroll period in which the Participant terminated employment or otherwise ceases to be eligible for such reimbursements. However, such Participant (or the Participant’s estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant’s estate) files a claim within the period set forth in Section 7.7(b).

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA."

5. In all other respects, the Plan, as amended, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this Fourth Amendment to be signed by its duly authorized representative.

DATED this 22 day of June, 2015.

ARIZONA BOARD OF REGENTS

By: [Signature]
Title: President

**FIFTH AMENDMENT TO
THE ARIZONA BOARD OF REGENTS PREMIUM PAYMENT,
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Premium Payment, Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees; and

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan; and

WHEREAS, in response to the 2019 novel coronavirus (COVID-19) outbreak, the IRS issued Notice 2020-29 permitting certain prospective midyear election changes for amounts contributed by Participants to their Health FSA and DCAP Accounts;

WHEREAS, Code § 106(f) was amended by the CARES Act (Pub. L. No. 116-136, §3702 (2020)) permitting the reimbursement of over-the-counter drugs from a Participant's Health FSA Account;

WHEREAS, the IRS has issued Notice 2020-33 increasing the carryover limit of unused amounts remaining as of the end of the Plan Year in a Participant's Health FSA to 20% of the maximum annual benefit amount that a Participant may elect to receive under the Plan in the form of reimbursement for Medical Care Expenses

under Code § 125(i) (as increased by cost-of-living adjustments announced by the IRS pursuant to the provisions of Code § 125(i)(2));

WHEREAS, the Board wishes to amend the Plan to (1) permit prospective midyear election changes for amounts contributed by Participants to their Health FSA and DCAP Accounts; (2) permit the reimbursement of over-the-counter drugs from a Participant's Health FSA Account, (3) increase the carryover limit of unused amounts remaining as of the end of the Plan Year in a Participant's Health FSA, (4) extend the period a Participant may apply for reimbursement from the Participant's Health FSA and DCAP Accounts for claims incurred during the 2019 Plan Year and (5) provide for a Grace Period following the close of the 2020 and 2021 Plan Years for a Participant to incur Dependent Care Expenses that may be reimbursed from the Participant's DCAP Account for the previous Plan Year; and

WHEREAS, the Board has determined that these amendments are required to assure the Plan's successful operation and administration and to maintain qualification of the Plan.

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. Additional Election Changes in Calendar Year 2020. Notwithstanding any other provisions in the Plan to the contrary, effective as of the dates when these provisions were put into operation but during calendar year 2020 only:

a. An Eligible Employee may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding the Health FSA. The Plan Administrator may further determine the extent to which such changes are permitted and applied. Any change allowed shall not permit a revocation or decrease in election below the amount already reimbursed.

b. An Eligible Employee may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding

the DCAP. The Plan Administrator may further determine the extent to which such changes are permitted and applied.

2. Reimbursement of Over-the-Counter Drugs. Effective for Medical Care Expenses incurred on and after January 1, 2020, Appendix A, which itemizes the “Medical Care Expenses” that are excluded and not eligible for reimbursement from the Health FSA Accounts of Participants, is amended by removing the requirement added by paragraph 5 of the First Amendment to the Plan (dated September 23, 2010 and effective January 1, 2011) that a medicine or drug shall be considered Medical Care Expenses only if the medicine or drug is a prescribed drug. Accordingly, effective January 1, 2020, a Participant may be reimbursed from the Participant’s Health FSA Account for over-the-counter drugs.

3. Indexing of Maximum Health FSA Carryover Amount. For Plan Years beginning on or after January 1, 2020, the maximum unused amount remaining in a Participant’s Health FSA Account at the end of a Plan Year that can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year shall be automatically increased to an amount equal to twenty percent (20%) of the maximum Health FSA salary reduction contribution under Code §125(i) (as increased by cost-of-living adjustments announced by the IRS pursuant to the provisions of Code § 125(i)(2)) for the Plan Year from which the amounts are carried over. Thus, the maximum unused amount that can be carried over from the Plan Year beginning January 1, 2020 to the Plan Year beginning January 1, 2021 is \$550.

4. Deadline for Submitting Claims. Notwithstanding the April 30, 2020 deadline set forth in Sections 7.7(b) and 9.7(b) of the Plan, a Participant shall have until June 30, 2020 to apply for reimbursement for Health FSA and DCAP Benefits for the Plan Year ending December 31, 2019. Effective for Plan Years beginning on and after January 1, 2020, the deadline to apply for reimbursement for Health FSA and DCAP Benefits shall again be April 30 of the following Plan Year.

5. Grace Period for Dependent Care Expenses. Section 9.4 of the Plan is amended by adding a new Section 9.4(e), that will be effective and apply only for the Plan Years ending December 31, 2020 and December 31, 2021, to read as follows:

“(e) Grace Periods; Special Rules for Claims Incurred During a Grace Period. Notwithstanding any contrary provision in this Plan (particularly Section 9.6) and subject to the conditions of Sections 9.4(b), an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in the Participant’s DCAP Account at the end of the Plan Year to which that Grace Period relates (“Prior Plan Year DCAP Amounts”) if he or she is a Participant in the Plan with DCAP coverage that is in effect on the last day of that Plan Year. This Section 9.4(e) shall be administered as follows:

- 'Grace Period' means the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.
- Prior Plan Year DCAP Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year DCAP Amounts may not be used to reimburse Medical Care Expenses.
- Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 9.7 will be reimbursed first from any available Prior Plan Year DCAP Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year DCAP Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year DCAP Amounts.
- Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than the April 30 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year DCAP Amounts. Any Prior Plan Year DCAP Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 9.6."

6. In all other respects, the Plan, as amended, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this Fifth Amendment

to be signed by its duly authorized representative.

DATED this 19th day of November, 2020.

ARIZONA BOARD OF REGENTS

By: 
 Title: Chair

**SIXTH AMENDMENT TO
THE ARIZONA BOARD OF REGENTS PREMIUM PAYMENT,
HEALTH AND DEPENDENT CARE CAFETERIA PLAN
As Amended and Restated Effective
January 1, 2010**

WHEREAS, the Arizona Board of Regents (the "Board") adopted The Arizona Board of Regents Premium Payment, Health and Dependent Care Cafeteria Plan (the "Plan"), originally effective as of April 1, 1991, and thereafter amended and restated the Plan, effective January 1, 2010, to provide certain cafeteria plan benefits to its employees;

WHEREAS, the Board is authorized, pursuant to Section 15.3 of the Plan, to adopt amendments to the Plan;

WHEREAS, in response to the 2019 novel coronavirus (COVID-19) outbreak, in 2020 the Board adopted a Fifth Amendment to the Plan to incorporate changes authorized by the IRS and amendments to the Internal Revenue Code to relax some of the rules applicable to cafeteria plans described in Code § 125;

WHEREAS, Congress has now enacted the Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260) and the IRS has issued Notice 2021-15 further relaxing rules applicable to cafeteria plans by extending grace periods or permitting carry forward of FSA and DCAP account balances into succeeding years;

WHEREAS, the IRS has also released Announcement 2021-7 permitting health FSAs under cafeteria plans to reimburse personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 ("COVID-19 PPE");

WHEREAS, On March 13, 2020, President Donald J. Trump signed the Proclamation on Declaring a National Emergency Concerning the COVID-19 Outbreak (the “COVID-19 National Emergency”) and thereafter on April 28, 2020, the Department of Labor, the Department of the Treasury, and the IRS issued a joint proclamation in the Federal Register (the “Joint Notice”) (which was thereafter interpreted by EBSA Disaster Relief Notice 2021-01 (“Notice 2021-01”)) requiring certain group health plans subject to the Employee Retirement Income Security Act of 1974 (“ERISA”) and the Internal Revenue Code (the “Code”) to allow plan participants and beneficiaries additional time to comply with certain deadlines, including making claims under such plans;

WHEREAS, although the Plan is not subject to ERISA and only certain provisions in the Plan are subject to the Code, the Board has determined that the time deadlines for all claims made during the COVID-19 National Emergency shall be extended in accordance with the Joint Notice, Notice 2021-01 and any other guidance issued hereafter (collectively referred to as the “Notices”);

WHEREAS, the Board wishes to amend the Plan to (1) permit the carryover of unused account balances in a Participant’s Health FSA Account from the 2020 and 2021 Plan Years to the immediately succeeding Plan Year; (2) extend the Grace Period a Participant may apply for reimbursement from the Participant’s DCAP Account for claims incurred during the 2020 and 2021 Plan Years to the end of the immediately succeeding Plan Year; (3) permit the reimbursement for COVID-19 PPE from a Participant’s Health FSA Account; and (4) extend the deadline for submitting

claims for reimbursement under the Plan and the time period for appealing the denial of any such claim or an appeal in accordance with the Notices; and

WHEREAS, the Board has determined that these amendments are required to assure the Plan's successful operation and administration and to maintain qualification of the Plan.

NOW, THEREFORE, pursuant to the authority granted to the Board in Section 15.3 of the Plan, the Plan is hereby amended as follows:

1. Carryover of Unused Amounts. Notwithstanding the provisions of Section 7.6 of the Plan, any unused balance remaining in the Participant's Health FSA Account at the end of the 2020 and 2021 Plan Years shall be carried forward to the immediately succeeding Plan Year to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year. If the Participant was enrolled in the General-Purpose Health FSA Option described in Section 7.3(b) in the Plan Year from which the carryover amount is carried into a subsequent Plan Year and if the Participant is enrolled in the Limited Health FSA Option described in Section 7.3(b) in the subsequent Plan Year, any amounts carried forward into the subsequent Plan Year may only be used to reimburse Medical Care Expenses incurred in the subsequent Plan Year that are eligible for reimbursement under the Limited Health FSA Option.

2. Grace Period for Dependent Care Expenses. Notwithstanding Section 9.4(e) of the Plan (as added by the Fifth Amendment to the Plan), for the Plan Years ending December 31, 2020 and 2021, the term "Grace Period" for DCAP Benefits shall mean the period that begins immediately following the close of a Plan Year and ends on December 31 of the immediately succeeding Plan Year.

3. Reimbursement of COVID-19 PPE. Effective January 1, 2020, the term "Medical Care Expenses" for a General-Purpose Health FSA Option as defined in Section 7.3 of the Plan is hereby amended to include expenses incurred by a Participant or his or her Spouse or Dependents for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 ("COVID-19 PPE").

4. Extension of Claims Periods. Effective with respect to any claims or appeals therefrom within the time frame included within the Notices, the time periods for a Participant or Beneficiary to comply with the filing of such claims or appeals shall be extended as set forth in the Notices.

5. In all other respects, the Plan, as amended, is hereby affirmed.

IN WITNESS WHEREOF, the Board has caused this Sixth Amendment to be signed by its duly authorized representative.

DATED this 14th day of June, 2021.

ARIZONA BOARD OF REGENTS

By: 
Title: Chair, Arizona Board of Regents