

**UNIVERSITY OF ROCHESTER
RETIREE HEALTH REIMBURSEMENT
ARRANGEMENT**

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**UNIVERSITY OF ROCHESTER RETIREE
HEALTH REIMBURSEMENT ARRANGEMENT**

INTRODUCTION

The University of Rochester has adopted this Retiree Health Reimbursement Arrangement (the “Plan”) for the purpose of allowing Eligible Retirees and Eligible Dependents to obtain reimbursement of premiums paid for supplemental Medicare coverage purchased through the Via Benefits Individual Marketplace. Such coverage includes individual Medigap plans, Medicare Advantage Plans, and Medicare Part D Plans offered through the Via Benefits Individual Marketplace (collectively, the “Medicare Supplement Plans”). Additionally, certain participants who purchase Medicare Supplement Plans may obtain reimbursement of the premiums they pay for: (i) University of Rochester retiree dental or vision coverage; or (ii) dental or vision coverage through certain other eligible plans.

**ARTICLE I
IMPORTANT TERMS**

1.1 Name of Plan. University of Rochester Retiree Health Reimbursement Arrangement

1.2 Plan Sponsor. University of Rochester

Contact Name: Associate Vice President of Human Resources

Address: 60 Corporate Woods, Suite 310, Rochester, NY 14627-0453

Telephone Number: 585-275-2084

Tax Identification Number: 16-0743209

1.3 Plan Administrator and Agent for Service of Legal Process. Associate Vice President of Human Resources

Address: 60 Corporate Woods, Suite 310, Rochester, NY 14627-0453

Telephone Number: 585-275-2084

1.4 Claims Administrator. Extend Health, LLC (d/b/a Via Benefits)

Address: P.O. Box 981155, El Paso, TX 79998-1155

Telephone Number: (866) 886-0879

1.5 Plan Number. 523

1.6 Effective Date. January 1, 2021

1.7 Eligible Retiree. Eligible Retiree means a former employee of the Plan Sponsor who is eligible for Medicare, has satisfied the requirements for being treated as a Retiree and has purchased a Medicare Supplement Plan through the Via Benefits Individual Marketplace. Eligible Retirees whose employment was covered by a collective bargaining agreement will only be eligible for benefits to the extent provided in those agreements. Copies of such agreements are available upon written request.

1.8 Eligible Dependent: Eligible Dependent means.

(a) an Eligible Retiree's Medicare-eligible Spouse who has purchased a Medicare Supplement Plan through the Via Benefits Individual Marketplace; or

(b) an Eligible Retiree's Medicare-eligible Domestic Partner who has purchased a Medicare Supplement Plan through the Extend Health Individual Marketplace.

Special rules for certain Eligible Dependents are set forth at Exhibit A. An Eligible Retiree's Spouse or Domestic Partner may commence participating in the Plan before the Eligible Retiree if the Eligible Retiree would otherwise satisfy the requirements for eligibility but has not yet satisfied the age requirements for eligibility for Medicare benefits.

Medicare-eligible surviving Eligible Dependents of deceased active Regular Full-time and Part-Time faculty/staff members who had met the age and service requirements to Retire with a Post-Retirement Level of 1R, 2R, or 3R benefit but were not Retired at the time of their death, are also eligible to commence coverage under this Plan upon the Eligible Retiree's death. In addition, Medicare-eligible surviving Eligible Dependents of a deceased active Regular Full-Time or Part-Time faculty/staff member who had five or more years of service and satisfied the requirement for a Post-Retirement Level of 1R, 2R, or 3R benefit but had not met the criteria to retire at the time of death are eligible to commence coverage under this Plan for a period of one year following the active Regular Full-Time or Part-Time faculty/staff member's death.

1.9 Reimbursable Expenses. Reimbursable Expenses are the cost of premiums for Medicare Supplement Plans purchased through the Via Benefits Individual Marketplace and, if applicable, the cost of premiums for: (i) University of Rochester retiree dental or vision coverage; or (ii) dental or vision coverage through certain other eligible plans.

1.10 Benefit Credit.

- (a) Exhibit A sets forth the amount that will be credited on behalf of Participants who are Eligible Retirees. The Plan Sponsor reserves the right to change these amounts at any time.
- (b) Exhibit A sets forth the amount that will be credited on behalf of Participants who are Eligible Dependent Spouses. The Plan Sponsor reserves the right to change these amounts at any time.

When a Participant first commences participation in the Plan, the Participant's Benefit Credit for such calendar year shall be prorated to reflect the portion of the Plan Year during which the Participant participated in the Plan.

1.11 Combined Account. A single HRA Account will be established for all Participants in a single family, and all Benefit Credits for all such Participants will be credited to such HRA Account.

1.12 Timing of Credit. Benefit Credits specified in Section 1.10 will be credited to HRA Accounts as of the first business day in January of each calendar year; provided in the first year when a Participant commences participation the Plan, the Participant's prorated Benefit Credit shall be credited as soon as administratively practicable after commencement.

1.13 Carryover of Accounts. Benefit Credits remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall generally be carried over to the following Plan Year to reimburse Participants for Reimbursable Expenses incurred during subsequent Plan Years.

1.14 Death – New Benefit Credits. Participants who are Eligible Dependents shall continue to receive new Benefit Credits under Section 1.10 after the Eligible Retiree’s death to the extent provided in Exhibit A.

ARTICLE II DEFINITION OF TERMS

2.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below.

- (a) “Affiliate” means any entity which, with the Plan Sponsor, is a member of a controlled group of corporations, a group of trades or businesses under common control, an affiliated service group, or a group of corporations otherwise required to be aggregated, as provided in Code Sections 414(b), (c), (m), and (o), respectively.
- (b) “Appointment” means the action which begins a relationship with the University in a specific position, such as member of the faculty; the period during which such a relationship is in effect.
- (c) “HRA Account” means the notional account established for a Participant to account for his or her Benefit Credits.
- (d) “Benefit Credit” means the amount credited to a Participant’s HRA Account for the provision of benefits under the Plan as provided in Section 4.2.
- (e) “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
- (f) “Code” means the Internal Revenue Code of 1986, as amended from time to time.
- (g) “Continuous Employment” means actively at work in a position eligible for the full range of University Benefit Plans. Absences from a position eligible for the full range of University Benefit Plans due to Leave of Absence or Layoff would be included in determining continuous employment.
- (h) “Dependent” means the Spouse or Domestic Partner of an Eligible Retiree.
- (i) “Domestic Partner” means an individual who satisfies all of the following requirements with respect to an Eligible Retiree:
 - Have an exclusive mutual commitment, similar to that of marriage;
 - Are each other’s sole domestic partner and intend to remain so indefinitely;
 - Are not legally married to anyone else under a marriage recognized by state or federal law;

- Are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which the
- partners legally reside;
- Are at least 18 years of age and are legally competent to contract;
- Are currently residing together and have resided together in a common household for at least six consecutive months and intend to reside together indefinitely;
- At least six months have elapsed since the Office of Total Rewards has received a Statement of Termination of a previous domestic partnership from either partner; and
- Share joint responsibility for the partners' common welfare and financial obligations demonstrated by:
 - the existence of a domestic partner agreement (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e., joint and several liability for each other's debts and expenses, responsibility for mutual care, etc.); and
 - at least two other items showing joint responsibility, such as joint bank accounts; joint deed; mortgage agreement or lease; joint credit account or other liability; joint ownership of a motor vehicle; designation of domestic partner as primary beneficiary for life insurance or retirement contract(s); designation of domestic partner as primary beneficiary of will, durable property, or health care power of attorney; coparenting agreement, or an adoption agreement.

An Eligible Retiree who wants to enroll his or her domestic partner in the University's benefit plans must have a domestic partner agreement that legally binds a retiree and his or her domestic partner to joint responsibility for their common welfare and financial obligations. Executing and filing a Statement of Domestic Partnership with the City Clerk of City of Rochester will satisfy this requirement. The Office of Total Rewards has the right to request the Eligible Retiree to produce a copy of this agreement and/or other information that indicates joint financial responsibility, such as joint bank accounts or joint liability on mortgages or other debts, etc. The Eligible Retiree must also sign and file with the Office of Total Rewards the University's Certification of Domestic Partner Status. The Certification covers all eligible domestic partner benefits (i.e., the University's health care, dental care, life insurance, long-term care, and tuition assistance programs). If an Eligible Retiree's domestic partnership ends, then the University must be notified within 60 days of the terminated relationship. An

Eligible Retiree satisfies this requirement by filing a Statement of Termination of Domestic Partnership with the Office of Total Rewards.

Please note: An Eligible Retiree will be taxed on the value of the Eligible Retiree's domestic partner's health/dental coverage if the domestic partner does not qualify as the Eligible Retiree's federal tax dependent.

- (j) "Eligible Dependent" means any Dependent who has satisfied the requirements of Section 1.8.
- (k) "Eligible Retiree" means any former employee of the Plan Sponsor who, as of his or her retirement from the Plan Sponsor, satisfies the eligibility requirements specified by the Plan Sponsor in Section 1.7.
- (l) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- (m) "Full-Time" means, for hourly staff: a regular weekly work schedule of at least 35 hours; for professional, administrative, and supervisory staff: a weekly work schedule of 40 hours or more; for faculty: a normal full teaching and research load as defined for the faculty by the college or school concerned.
- (n) "Retiree Level" means the Post-Retirement Benefits Program to which a Retiree is assigned, determined by the Retiree's most recent date of Hire or Rehire, Continuous Employment, Retirement eligibility date, and Retirement date.
- (o) "Hired", for purposes of determining Post-Retirement Benefits, "means an Appointment to a position that is eligible for the full range of University Benefit Plans.
- (p) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.
- (q) "Layoff (indefinite)" means an indefinite suspension of University employment because of reduction of staff or elimination of a position for more than four months or for unspecified duration, not over one year.
- (r) "Layoff (temporary)" means a temporary suspension of University employment because of reduction of staff or elimination of a position with the expectation of return to work within four months of the day the layoff begins.
- (s) "Leave of Absence" means an approved absence which does not end, but does change, the Appointment relationship. Leave may be for research or study, to permit a visiting appointment elsewhere, for personal reasons, or for disability.

- (t) “Medicare Supplement Plans” means individual Medigap plans, Medicare Advantage Plans, and Medicare Part D Plans purchased through the Via Benefits Individual Marketplace.
- (u) “Participant” means each Eligible Retiree or, his or her Eligible Dependent, who has satisfied the eligibility requirements of Article III hereof and has not, for any reason, become ineligible to participate in the Plan.
- (v) “Part-Time” means a regular weekly or monthly schedule which is less than that required for Full-Time status but generally not less than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff. For faculty it indicates that the individual carries at least half the normal (full) teaching and research load as defined for faculty by the college or school concerned.
- (w) “Plan” means the health reimbursement arrangement named in Section 1.1 and set forth herein, as may be amended from time to time.
- (x) “Plan Year” means the calendar year.
- (y) “PHI” means protected health information as described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Plan.
- (z) “Regular” means a period of Appointment in hourly and professional, administrative, and supervisory positions that is expected to exceed four months, unless otherwise defined in collective bargaining agreements; period of Appointment for faculty-instructional staff that is at least one year (or one academic year) or, if shorter, is expected to be renewed. Appointments primarily for furthering education (for example, graduate assistant) are not considered “regular” Appointments.
- (aa) “Rehired”, for purposes of determining Post-Retirement Benefits, “Rehired” means an Appointment to a position that is eligible for the full range of University Benefit Plans from an Appointment that was not eligible for the full range of University Benefit Plans or following Termination or Retirement.
- (bb) “Reimbursable Expense” means the cost of a Participant’s premiums for Medicare Supplement Plans purchased through the Via Benefits Individual Marketplace and, if applicable, the cost of premiums for: (i) University of Rochester retiree dental or vision coverage; or (ii) dental or vision coverage through certain other eligible plans. Notwithstanding the forgoing, Reimbursable Expenses shall not exceed the amount credited to the Participant’s HRA Account.
- (cc) “Retirement or Retire” mean the ending of Appointment (whether voluntary or involuntary) after satisfying the requirements to be treated as a Retiree.

(dd) “Retiree” means the University Retired faculty and staff members who satisfy the following:

- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired prior to 1/1/96 who: (1) Retire after age 55 and before 2024, and (2) who have completed 10 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 10 Years of Service requirement may be met by cumulative employment at the University or another higher education institution).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired on or after 1/1/96 who: (1) Retire after age 60 and before 2024, and (2) have completed 10 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 10 Years of Service requirement may be met by cumulative employment at the University or another higher education institution as long as there is Continuous Employment at the University for the immediate five years prior to Retirement).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired prior to 1/1/96 who: (1) Retire after age 55 and after 2023, and (2) who have completed 15 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 15 Years of Service requirement may be met by cumulative employment at the University or another higher education institution).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired on or after 1/1/96 who: (1) Retire after age 60 and after 2023, and (2) have completed 15 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 15 Years of Service requirement may be met by cumulative employment at the University or another higher education institution as long as there is Continuous Employment at the University for the immediate five years prior to Retirement).

Once Retired, Post-Retirement Benefits continue to be based on employment status, age, and years of service at the time of initial Retirement, even if the Retiree returns to work. There is no adjustment to the Retiree Level, Years of Service, or age calculation to determine the level of Post-Retirement Benefits based upon Post-Retirement Rehire and employment.

(ee) “Spouse” means the person who is legally married under any applicable state or foreign law to the Eligible Retiree determined as of the applicable time by the Plan Administrator.

(ff) “Termination” means the ending of Appointment for reason other than Retirement.

(gg) “Years of Service” means years of service at work in a position eligible for the full range of University Benefit Plans as calculated from the credited service records maintained by the Plan Administrator.

2.2 Gender and Number. When used in this Plan, the masculine shall include the feminine, the singular shall include the plural, and vice versa.

**ARTICLE III
PARTICIPATION**

3.1 Agreement to Participate. An Eligible Retiree and his or her Eligible Dependent, shall become a Participant in this Plan on the date he or she has:

- (a) Satisfied the requirements to become an Eligible Retiree or Eligible Dependent, as applicable;
- (b) Obtained an individual health insurance policy through the Via Benefits Individual Marketplace; and
- (c) Completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

3.2 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

- (a) with respect to an Eligible Retiree, the date he or she ceases to be an Eligible Retiree for any reason, including death;
- (b) with respect to an Eligible Dependent, the date he or she ceases to be a Dependent for any reason, including death;
- (c) with respect to a Participant, the date the Participant is rehired as an active employee of the Plan Sponsor or any Affiliate or, in the case of an Eligible Dependent, the Eligible Dependent's Spouse or Domestic Partner is rehired as an active employee of the Plan Sponsor or any Affiliate;
- (d) the effective date of any Plan amendment that renders him or her ineligible to participate; or
- (e) the termination of the Plan.

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by Section 5.3.

A surviving Eligible Dependent of a deceased Eligible Retiree who is a 4R or 5R Participant (see Exhibit A) will not be credited with any Benefit Credit after the Eligible Retiree's death and are subject to the following rules:

- (a) Such surviving Eligible Dependent will have a 12 month spend down period from the date of the Eligible Retiree's death to use the remaining balance of funds in the HRA Account.
- (b) Such surviving Eligible Dependent can continue to incur new claims during the 12 month spend down period following the death of the Eligible Retiree.

- (c) At the end of the 12 month spend down period, such surviving Eligible Dependent will have a 6 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed.

ARTICLE IV FUNDING

4.1 Funding. The benefits provided herein shall be provided by the Plan Sponsor out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a notional account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan or that are protected from the reach of the Plan Sponsor's creditors. In no event may any benefits under the Plan be funded with Participant contributions.

4.2 Benefit Credits. The Plan Sponsor shall credit HRA Accounts of Participants with the Benefit Credits specified in Section 1.10 at the time or times specified in Section 1.12. The Benefit Credit to be made on behalf of a Participant who is an Eligible Dependent shall be made to the combined HRA Account. No earnings shall be credited at any time with respect to any HRA Account.

4.3 Mistaken Credits. If the Plan Sponsor has credited an HRA Account and such credit was for an incorrect amount or was in error, the Plan Sponsor may correct such mistaken credits by deducting them from the HRA Account balance as soon as reasonably practicable. To the extent that such mistaken credit has already been deducted from the HRA Account for Reimbursable Expenses, the Plan Sponsor may request that the Participant pay back the mistaken credit, may offset future eligible claims against the mistaken credit, or may collect the mistaken credit by using any other method in accordance with applicable law.

ARTICLE V BENEFITS

5.1 Provision of Benefits. The Plan will reimburse Participants for Reimbursable Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Reimbursable Expenses incurred after he or she becomes a Participant in the Plan and before his or her participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Reimbursable Expenses.

5.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Reimbursable Expenses in an amount that does not exceed the balance of his or her HRA Account. Each reimbursement hereunder shall be a deduction to such HRA Account available to pay Reimbursable Expenses under the Plan.

5.3 Expense Reimbursement Procedure. Reimbursement for Reimbursable Expenses shall be made in accordance with this Section 5.3.

- (a) *Timing:* A Participant desiring to receive reimbursement for Reimbursable Expenses under this Plan shall submit a written application to the Claims Administrator. Notwithstanding the preceding, upon loss of eligibility as provided in Section 3.2, coverage under the Plan ceases, the Participant shall receive no further Benefit Credits under the Plan, and his or her Reimbursable Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Reimbursable Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days following the last day of the Plan Year when the Participant loses eligibility.
- (b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation to pay Reimbursable Expenses. The Claims Administrator will reimburse the Participant from the general assets of the Plan Sponsor for expenses that it determines are Reimbursable Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Reimbursable Expenses prior to reimbursement. Unless a Reimbursable Expense satisfies the Claims Administrator's procedures for automatic substantiation pursuant to the requirements of Code Section 213(d), each request for reimbursement shall include the following information to the extent required by the Plan Administrator:
 - the amount of the Reimbursable Expense for which reimbursement is requested;

- the date the Reimbursable Expense was incurred;
- a brief description and the purpose of the Reimbursable Expense;
- the name of the person for whom the Reimbursable Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
- the name of the entity to whom the Reimbursable Expense was or is to be paid;
- a statement that the Participant has not been and will not be reimbursed for the Reimbursable Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Reimbursable Expense under Code Section 213; and
- A written bill from an independent third party stating that the Reimbursable Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Claims will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

- (c) *Timing:* The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial thirty (30)-day period that the Claims Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Claims Administrator. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Claims Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

- the specific reason or reasons for the denial;
- specific reference to pertinent plan provisions on which denial is based;

- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
 - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.
- (d) *Claims Denied:* Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 7.7.
- (e) *Simplified Reimbursement Process.* The Claims Administrator may establish a simplified reimbursement process for the payment of health insurance premiums. Such procedures may involve the direct payment of the health insurance premium from the Participant's HRA Account to the carrier. Such process will be considered to be a reimbursement from the Participant's HRA Account and will be structured to satisfy the requirements for a reimbursement as set forth in this Section.
- (f) *Auto Reimbursement.* The Claims Administrator may establish an auto reimbursement process for the payment of health insurance premiums, and such auto reimbursements shall not be considered to be claims for benefits. In establishing and operating such auto reimbursement process, the Claims Administrator may establish a process to remove and prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall not be considered to be claims for benefits.
- (g) *Mode of Reimbursement.* The Claims Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.
- (h) *Forfeiture of Unclaimed Reimbursements.* Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit 18 months after the check was mailed or the payment was otherwise attempted. If the payee or other person contacts the Claims Administrator prior to the 18-month forfeiture time frame, the Claims Administrator shall cancel and void the original check or payment and shall re-issue a new check. If the payee does not contact the Claims Administrator prior to the 18-month forfeiture time frame, the unclaimed check or unclaimed payment

shall be voided and the amount of the voided check or payment shall be considered to be Benefit Credit as of such date and shall be credited to the Participant's HRA Account as of such date. If the Participant's HRA Account has been closed as of the date such Benefit Credit would otherwise be made, the Benefit Credit shall not be made, but rather shall be forfeited.

5.4 Carryover of Accounts. To the extent a Participant has a balance in his or her HRA Account at the end of a Plan Year, the balance shall be carried over to following Plan Years.

5.5 Death.

- (a) In the event an Eligible Retiree dies with no Eligible Dependents who are Participants, his or her HRA Account shall be forfeited upon his or her death; provided, however, that his or her estate or representatives may submit claims for Reimbursable Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one year after the Eligible Retiree's death.
- (b) In the event an Eligible Retiree dies with an Eligible Dependent who is a Participant who is entitled to receive Benefit Credits to the HRA Account after the Eligible Retiree's death, his or her HRA Account shall continue and such Eligible Dependent may continue to submit Reimbursable Expenses for reimbursement in the normal course. Upon such Eligible Dependent's death, his or her HRA Account shall be forfeited; provided, however, that his or her estate or representatives may submit claims for Reimbursable Expenses incurred by the Eligible Dependent prior to the Eligible Dependent's death, as long as such claims are submitted no later than one year after the Eligible Dependent's death.
- (c) A surviving Eligible Dependent of a deceased Eligible Retiree who is a 4R or 5R Participant (see Exhibit A) will not be credited with any Benefit Credit after the Eligible Retiree's death and the HRA Account shall be forfeited upon the Eligible Retiree's death subject to the following rules:
 - Such surviving Eligible Dependent will have a 12 month spend down period from the date of the Eligible Retiree's death to use the remaining balance of funds in the HRA Account.
 - Such surviving Eligible Dependent can continue to incur new claims during the 12 month spend down period following the death of the Eligible Retiree.
 - At the end of the 12 month spend down period, such Surviving Eligible Dependent will have a 6 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed.

- (d) In the event an Eligible Dependent who is a Participant dies, the HRA Account shall continue, but no further Benefit Credits shall be made to the HRA Account on behalf of the deceased Eligible Dependent.

5.6 Nondiscrimination. The Plan Administrator may limit, reallocate or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

5.7 Recovery of Improper Payments.

- (a) Recovery: If any Participant, Dependent, individual, person, entity or party (the "Recipient") receives, directly or indirectly, an Improper Payment (as defined below) from the Plan, the Recipient must pay back to the Plan the full amount of the Improper Payment pursuant to the applicable rules and procedures of the Plan Administrator. In addition, any Participant and Dependent to whom the Improper Payment relates and any other individual, person, entity or party that the Plan Administrator determines to be involved with or related to the Improper Payment (a "Related Party") must assist the Plan Administrator in recovering the Improper Payment from the Recipient.
- (b) Penalties: If a Participant, Dependent, Recipient or Related Party that is required to repay an Improper Payment or assist in recovering an Improper Payment under subsection (a) fails to repay or assist in a recovery of an Improper Payment, the Plan Administrator shall have the right, in its sole discretion:
 - (1) To suspend the payment of all Plan benefits to or on behalf of the Participant, Dependent, Recipient or Related Party for any period of time that the Plan Administrator deems appropriate; and
 - (2) To terminate the participation in the Plan of the Participant, Dependent, Recipient or Related Party for any period of time that the Plan Administrator deems appropriate.
- (c) Other Remedies. Nothing in this Section shall restrict, limit or otherwise hinder the Plan from pursuing any of its rights or remedies to recover Improper Payments under any applicable law.
- (d) Improper Payment Defined. Any payment of Plan benefits that the Plan Administrator determines, in its discretion, to be improper under the terms of the Plan, including:
 - (1) Payments of Plan benefits that have been directed to or received by the wrong Recipient;
 - (2) Payments of Plan benefits that have not been properly authorized by the Plan Administrator; or

- (3) Plan benefits that have been paid based on incorrect, missing or false information with respect to the coverage of a Participant or Dependent.

5.8 Overpayments.

- (a) General. The Plan Administrator shall take such steps as it deems necessary to obtain prompt repayment of any Overpayments (as defined below) made under or relating to the Plan, including requiring immediate repayment where it deems appropriate. Current or future Plan benefits may be reduced (in whole or in part) at any time to recover any Overpayment. Nothing in this Section shall restrict, limit or otherwise hinder the Plan from pursuing any of its rights or remedies to recover Overpayments under any applicable law.
- (b) Overpayments. For purposes of this Section, the term, "Overpayment," shall include (1) any payment of Plan benefits received by or on behalf of the Participant or Eligible Dependent, which the Participant or Eligible Dependent is not entitled to under the terms of the Plan, and (2) any payment of Plan benefits received by or on behalf of the Participant or Eligible Dependent, which are in excess of the amount necessary to satisfy the requirements of this Plan. The term "Overpayment" shall also include any legal costs, attorneys' fees and court costs incurred as a result of or relating to the Overpayment.

ARTICLE VI CONTINUATION COVERAGE

6.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below:

- (a) “COBRA Continuation Coverage” means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.
- (b) “Election Period” means a period of at least sixty (60) days’ duration that begins not later than the date on which the Qualified Beneficiary’s coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends sixty (60) days after the later of: (1) the date such coverage would otherwise end, or (2) the date that the Qualified Beneficiary receives notice of his or her right to continued coverage under the Plan pursuant to Section 6.4.
- (c) “Qualified Benefits” means the HRA benefit under this Plan.
- (d) “Qualified Beneficiary” means the Participant’s Spouse, former Spouse or Domestic Partner.
- (e) “Qualifying Event” means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:
 - the death of a Participant; or
 - the divorce or legal separation of a Participant and his or her Spouse.
- (f) “Similarly Situated Beneficiary” means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

6.2 COBRA Continuation Coverage. The Spouse or former Spouse of a Participant may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 6.1(e).

6.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to thirty-six (36) months, but shall be terminated earlier upon the occurrence of any of the following events:

- (a) The date the Qualified Beneficiary's HRA Account is exhausted;
- (b) The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- (c) Any required monthly premium is not paid when due or during the applicable grace period;
- (d) The date, after the date of the Qualified Beneficiary's COBRA election, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary; or
- (e) The Plan Sponsor and its Affiliates cease to provide any group health plan to any employee.

6.4 Notices.

- (a) Qualified Beneficiaries must notify the Plan Administrator in writing within sixty (60) days of a Qualifying Event described in Section 6.1(e)(2) or (3).
- (b) The Plan Sponsor must notify the Plan Administrator within thirty (30) days of any Qualifying Event described in Section 6.1(e)(1).
- (c) Within fourteen (14) days of its receipt of any notice required by subsection (a) or (b) of this Section, the Plan Administrator shall notify the Qualified Beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse of a Participant by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

6.5 Election of Coverage. Upon notification by the Plan Administrator of his or her right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

6.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued coverage, such premium to be one hundred and two percent (102%) of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within forty-five (45) days of the date the COBRA Continuation Coverage is elected under Section 6.5.

ARTICLE VII ADMINISTRATION

7.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated under the Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

7.2 Duties of the Plan Administrator.

- (a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.
- (b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.
- (c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
 - To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
 - To prepare and distribute information explaining the Plan to Participants;
 - To receive from Participants and Dependents such information as shall be necessary for the proper administration of the Plan;
 - To keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;
 - To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;
 - To accept, modify or reject Participant elections under the Plan;
 - To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;
 - To determine and enforce any limits on benefit elections hereunder; and
 - To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover

erroneous overpayments made by the Plan to a Participant or Dependent, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or Dependent.

7.3 Allocation and Delegation of Duties.

- (a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or member to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.
- (b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.
- (c) The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Plan or in furtherance of its duties hereunder shall be paid by the Plan by reduction of Participant HRA Accounts to the extent not paid by the Plan Sponsor.

7.4 Indemnification. The Companies, jointly and severally, shall indemnify and save the Plan Administrator, and any employees to whom the Plan Administrator has allocated or delegated its responsibilities in accordance with the provisions hereof, harmless from and against all claims, losses, damages, expense, and liability arising from their responsibilities in connection with the administration and management of the Plan which is not otherwise paid or reimbursed by insurance, unless the same shall result from their own willful misconduct.

7.5 Bonding. The Plan Administrator, each person who is a fiduciary under the Plan and each person who handles funds of the Plan, shall be bonded in an amount no less than the amounts required by ERISA Section 412 and the regulations issued thereunder.

7.6 Claims Procedure.

- (a) Within one hundred and eighty (180) days of receipt by a claimant of a notice under Section 5.3 denying a claim in whole or in part, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:
- specific reasons for the decision;
 - specific references to the pertinent plan provisions on which the decision is based;
 - a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
 - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.
- (b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant challenges the decision of the Plan Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

- (c) A claimant who has exhausted his claims rights and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in the United States District Court for the Western District of New York to review the Plan Administrator's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

ARTICLE VIII HIPAA

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan Administrator and its contracted vendors (Business Associates) are required to follow specified procedures regarding the protection and transmission of Participants' protected health information (PHI). The benefits covered under the HIPAA Privacy and Security Practices include group health benefits under the Plan.

The Plan has updated its contracts and procedures to ensure compliance with this act. Upon eligibility to the Plan, and at least every three years thereafter, Participants' will be provided with a Notice of Privacy Practices outlining Participants' and the Plan's rights and obligations under HIPAA. Should Participants' require additional information, or to obtain a copy of the Notice of Privacy Practices, you may contact your Human Resources Representative. Attached is a Notice of Participants' HIPAA Privacy Practices. Participants' can also obtain a copy of the Notice of Privacy Practices online at http://rochester.edu/working/hr/benefits/library/privacy_practice.pdf.

ARTICLE IX GENERAL PROVISIONS

9.1 Amendment and Termination. Although the Plan Sponsor intends to maintain the Plan for an indefinite period, the Plan Sponsor and the Plan Administrator have the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts.

9.2 Plan Sponsor Liability. Benefits under the Plan are paid by the Plan Sponsor out of its general assets.

9.3 QMCSO. In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

9.4 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be treated as complete satisfaction of payment therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator and the Plan Sponsor.

9.5 Status of Benefits. Neither the Plan Sponsor nor the Plan Administrator 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 Plan Administrator or Plan Sponsor if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

9.6 Health Reimbursement Arrangement and Retiree Only Plan. The Plan is intended to qualify as a self-insured premium reimbursement plan for purposes of Code Section 106. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

9.7 Anti-assignment Provision. A participant's right to receive benefits under the Plan may not be assigned, voluntarily or involuntarily, to any other person. A medical service provider or insurer has no standing to bring a claim for benefits with respect to services it provides to a plan participant.

9.8 Misrepresentation or Fraud. To the extent permitted by law, the Plan Administrator reserves the right to terminate a participant's benefits, deny future benefits, take legal action against a participant, and/or set off from any future benefits the value of benefits the plan has paid relating to inaccurate information or misrepresentations provided to the plan, in the case of any participant who obtains benefits wrongfully due to intentional misrepresentation or fraud.

9.9 Venue and Time Limit for Bringing Lawsuits. A claimant who has exhausted his claims rights and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in the United States District Court for the Western District of New York to review the Plan Administrator's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal. A claimant that seeks to commence a lawsuit or legal action against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person or committee, in connection with the Plan must do so in the United States District Court for the Western District of New York. Such United States District Court is the sole forum for a claimant bringing a lawsuit.

9.10 Miscellaneous.

- The Employer makes no representation or warranty with respect to the quality or sufficiency of the services or supplies provided by others under the Plan or the Medicare Supplement Plans that may be purchased with funds made available under the Plan.
- The Employer makes no separate promise to pay benefits under Medicare Supplement Plans that may be purchased with funds made available under the Plan.
- The Employer makes no representation or warranty with respect to the tax treatment of any benefits provided by the Plan.

9.11 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of New York, to the extent not preempted by any Federal law.

9.12 Capitalized Terms. Capitalized terms shall have the meaning set forth in Articles I and II.

9.13 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this 28 day of June, 2021.

Plan Sponsor: 

By: Holly G. Crawford

Title: Sr. Vice President Admin. & Finance, CFO

Exhibit A

1R and 2R Participants: Retirees who retired prior to January 1, 1996 shall receive a monthly Benefit Credit of \$400 for the Retiree and \$400 for the Retiree's eligible Spouse or Domestic Partner (if any). In the event of the death of the Retiree, the Retiree's eligible Spouse or Domestic Partner shall continue to receive a monthly subsidy of \$400 per month for such individual's life.

3R Participant: Retirees who were eligible to retire as of January 1, 1996 (i.e., they satisfied the age and service requirements as of that date) but did not retire until after June 30, 1996 shall receive a monthly Benefit Credit of \$200 for the Retiree and \$200 for the Retiree's eligible Spouse or Domestic Partner (if any). In the event of the death of the Retiree, the Retiree's eligible Spouse or Domestic Partner shall continue to receive a monthly subsidy of \$200 per month for such individual's life.

4R Participant: For Full-Time Retirees (as defined below), Retirees whose most recent date of hire or rehire was before 1996, but were not eligible to retire as of January 1, 1996 (i.e., they did not satisfy the age and service requirements as of that date) shall receive a monthly Benefit Credit of \$200 for the Retiree and \$200 for the Retiree's eligible Spouse or Domestic Partner (if any). In the event of the death of the Retiree, no further subsidy shall be credited to the Retiree's spouse or domestic partner (if any).

5R Participants: For Full-Time Retirees (as defined below), Retirees who were hired or rehired on or after January 1, 1996, shall receive a monthly Benefit Credit of \$200. No credit will be provided for the Retiree's spouse or domestic partner (if any).

4R and 5R Participants who qualify as a Part-Time Retiree are eligible to receive a Benefit Credit that is 50% of the credit provided to a Full-Time Retiree. Whether a 4R or 5R Participant is treated as a Part-Time Retiree or Full-Time Retiree is based on whether the 4R or 5R Participant satisfies the applicable service requirement for being treated as 4R or 5R Participant based on Full-Time or Part-Time service.

For purposes of these calculations, Full-Time service is calculated by aggregating the aggregate number of days the 4R or 5R Participant worked as a Full-Time employee and converting such days into an equivalent number of Full-Time Years of Service. Likewise, Part-Time service is calculated by aggregating the aggregate number of days the 4R or 5R Participant worked as a Part-Time employee and converting such days into an equivalent number of Part-Time Years of Service.

When determining the number of Full-Time or Part-Time years of service the participant has, the following rules apply:

- Each year of Full-Time service will count as one year of Full-Time service and one year of Part-Time service
- Each year of Part-Time service will count as one year of Part-Time service and one half of a year of Full-Time service

For example, for a Retiree who is a 5R Participant, which requires 15 Years of Service:

- A 60 year old Retiree with 15 years of Full-Time service would receive the Full-Time Retiree benefit
- A 60 year old Retiree with 15 years of Part-Time service would receive the Part-Time Retiree benefit
- A 60 year old Retiree with 30 years of Part-Time service would receive the Full-Time Retiree benefit
- A 60 year old Retiree with 10 years of Full-Time and 10 years of Part-Time service would receive the Full-Time Retiree benefit
- A 60 year old Retiree with 10 years of Full-Times and 5 years of Part-Time service would receive the Part-Time Retiree benefit

The University of Rochester reserves the right to amend or terminate these subsidies at any time in its sole discretion.

LEGAL Notices

HIPAA NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or "Protected Health Information" ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" or "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is materially changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for plan administrative purposes or as otherwise permitted by federal law. This notice only applies to Protected Health Information or PHI as defined in the applicable HIPAA privacy rules.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for plan administrative purposes or as otherwise permitted by law. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the protected health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; or
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notwithstanding the above, and to the extent provided in applicable law, the Plan shall not use or disclose your PHI that is classified as genetic information for purposes of any underwriting activity.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person on your behalf has paid the health care provider and you have not requested reimbursement from the Plan.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a “Designated Record Set” or “DRS.” The DRS is the group of records maintained by or on behalf of the Plan contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Sponsor that duplicates information maintained by a Plan business associate in its DRS.

The Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing.

If you exercise your right to access your PHI, the Plan will respond to your request within 30 days, subject to a one-time extension of an additional 30 days. In the case of an extension, the Plan must provide you with a written explanation for the delay and the date by which it will respond to your request.

The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

C. Right to Amend PHI

If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (except where you are unable to request an amendment from the person or entity that created the PHI because the person or entity is no longer available); (2) the Plan determines the information to be accurate or complete;

(3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, a description of your right to submit a statement of disagreement and a description of your right to file a complaint with the Plan or with the Department of Health and Human Services.

D. Right to Receive an Accounting of PHI Disclosures

You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an authorization; or (4) disclosures made more than six years ago (or the inception of the Plan, whichever is later).

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. This time period may not be longer than six (6) years and may not include any disclosures of PHI made before the inception of the Plan. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these

rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: Notice of Breaches of Unsecured PHI

Under HIPAA, the Plan and its business associates, are required to maintain the privacy and security of your PHI. The goal of the Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as “breaches.” If a breach affects you and is related to unencrypted PHI, the Plan or its applicable business associate will notify you of the breach and the actions taken by the Plan or the business associate to mitigate or eliminate the exposure to you.

Section 5. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 7. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

COBRA NOTICE

Important Benefits Information Please read and retain with your insurance information

This Section of the Summary Plan Description is your General Notice of COBRA Continuation Coverage. You are receiving this notice because you have recently become covered under the University of Rochester Retiree Health Reimbursement Arrangement (the “Plan”). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the HRA benefits offered under the Plan.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse, if your spouse is covered under the Plan, when your spouse would otherwise lose coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the other sections of Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

What Is COBRA Continuation Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You and your spouse could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage.

Who Is Entitled to Elect COBRA?

If you are the spouse of the primary account holder, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies; or
- You become divorced or legally separated from your spouse.

Also, if your spouse (the retiree) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or

legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your sponsoring employer, and that bankruptcy results in the loss of coverage of any retired employee covered under a retiree plan of the employer, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the COBRA Administrator (as set forth at the end of this notice) has been timely notified that a qualifying event has occurred. When the qualifying event is the death of the primary account holder or commencement of a proceeding in bankruptcy with respect to the Plan sponsor, the Plan will offer COBRA coverage to qualified beneficiaries only after the COBRA Administrator is notified by the employer. Such notice must be provided within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the retiree and spouse) causing a loss of coverage, a COBRA election will be available to you only if you notify the COBRA Administrator by contacting the number below, or in writing within 60 days after the later of: (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed, or if the notice is not provided to the COBRA Administrator during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE. If you need help electing COBRA coverage on behalf of an incapacitated beneficiary, please contact the COBRA Administrator.

Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered primary account holders and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries.

Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your coverage plus a 2% administration fee.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the primary account holder or divorce or legal separation, COBRA coverage under the Plan's group health components can last for up to a total of 36 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in other sections of this Summary Plan Description.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator or COBRA Administrator.

Notice Procedures

If you are currently enrolled in COBRA coverage, your COBRA Administrator is: National Benefits Services

You may contact National Benefits Services, as follows:

- Online at <https://www.nbsbenefits.com/cobra-account-access/>
- By phone: 801-282-1269
- By mail to: National Benefit Services (NBS) 3736 Center Park Drive, #120, West Jordan, UT 84084

Notification sent by mail should include:

- The name of the Plan (i.e., The University of Rochester Retiree Health Reimbursement Arrangement)
- The name and address of the individual who is (or was) covered under the Plan
- The qualifying event and the date it happened
- The signature, name, address, and telephone number of the person providing the notification
- Any additional information required for the type of notice you are providing

Via Benefits is responsible for administration of your Health Reimbursement Arrangement.

You may contact Via Benefits as follows:

- Online at <https://my.viabenefits.com/universityofrochester>
- Phone: 1-833-945-1110
- By Mail to: Via Benefits, 10975 S. Sterling View Drive, South Jordan, UT 84095

Who May Provide Notice

The primary account holder (i.e., the retiree who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

ERISA RIGHTS STATEMENT

Participants in the Plan have certain legal rights under Federal law. The U.S. Department of Labor requires that you be informed of these rights in the following form:

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 series) (should it become necessary for the Plan to file a Form 5500), filed by the plan with the U.S. Department of Labor.
- Obtain upon written request to the Plan Administrator copies of documents governing the administration of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) (should it become necessary for the Plan to file a Form 5500) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.
- Receive a summary of the Plan's annual financial report (if a Form 5500 is filed). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (if a Form 5500 is filed).

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a health and welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the ERISA rights described herein. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the

Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**University of Rochester Retiree Health Reimbursement Arrangement
Adopted as of January 1, 2021**

Amendment No. 1

Effective as of January 1, 2023, the University of Rochester hereby amends the University of Rochester Retiree Health Reimbursement Arrangement, adopted as of January 1, 2021, (the "Plan") as follows:

1. Section 2.1(bb) of the Plan is amended by adding the following provision after the first sentence of such section:

Effective January 1, 2023, Reimbursable Expense shall include properly documented out-of-pocket expenses for "medical care" within the meaning of Code Section 213(d)(1)(A) or (B) that are not covered under another medical plan. Notwithstanding the foregoing, the following expenses are not eligible for reimbursement: Medicare Part A/B premiums; long term care premiums and hearing plan premiums.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 20 day of February, 2023.

UNIVERSITY OF ROCHESTER

By: _____

Title: VP for Human Resources, Chief Human Resources Officer

**University of Rochester Retiree Health Reimbursement Arrangement
Adopted as of January 1, 2021**

Amendment No. 2

Effective as of January 1, 2026, the University of Rochester hereby amends the University of Rochester Retiree Health Reimbursement Arrangement, adopted as of January 1, 2021, (the “Plan”) as follows:

1. Section 3.2 is amended to replace paragraph (c) regarding surviving Eligible Dependents with the following:

- (c) At the end of the 12 month spend down period, such Surviving Eligible Dependent will have a 12 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed. For Reimbursable Expenses incurred before January 1, 2026, at the end of the 12 month spend down period, such Surviving Eligible Dependent will have a 6 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed.

2. Section 5.3(a) of the Plan is replaced with the following:

Timing: For Reimbursable Expenses incurred on or after January 1, 2026, a Participant desiring to receive reimbursement under this Plan shall submit a written application to the Claims Administrator no later than twelve (12) months from the date on which the Reimbursement Expense is incurred. For Reimbursable Expenses incurred before January 1, 2026, a Participant desiring to receive reimbursement under this Plan shall submit a written application to the Claims Administrator no later than six (6) months from the date on which it the Reimbursement Expense is incurred.


Notwithstanding the preceding, upon loss of eligibility as provided in Section 3.2, coverage under the Plan ceases, the Participant shall receive no further Benefit Credits under the Plan, and his or her Reimbursable Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant’s HRA Account. The Participant may submit claims for reimbursement for Reimbursable Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within twelve (12) months following the last day of the Plan Year when the Participant loses eligibility. For Reimbursable Expenses incurred before January 1, 2026, the Participant may submit claims for reimbursement for Reimbursable Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days following the last day of the Plan Year when the Participant loses eligibility.

3. The third bullet in Section 5.5(c) of the Plan is replaced with the following:

- At the end of the 12 month spend down period, such Surviving Eligible Dependent will have a 12 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed. For Reimbursable Expenses incurred before January 1, 2026, at the end of the 12 month spend down period, such Surviving Eligible Dependent will have a 6 month run-out period in which claims incurred during or prior to the 12 month spend down period, can be submitted and reimbursed.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 19th day of December, 2025.

UNIVERSITY OF ROCHESTER

By: 
Name: Kathleen M. Gallucci
Title: Senior VP for HR and CHRO