NOTRE DAME DE NAMUR UNIVERSITY
SELF FUNDED HEALTH REIMBURSEMENT PLAN

Summary Plan Description

Originally Effective July 1, 2017
Amended and Restated as of July 1, 2020

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PLAN INFORMATION

This document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions related to this Plan and Notre Dame de Namur University's integrated group health plans ("Benefit Documents"), constitutes this Plan's Summary Plan Description ("SPD") pursuant to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan's benefits as of July 1, 2020, which may change from time to time. You should keep this SPD with the Benefit Documents provided to you upon enrollment in the Plan.

Plan Name:	Notre Dame de Namur University Self Funded Health Reimbursement Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	July 1 through June 30 of the following calendar year. The Plan is funded annually for Participants on January 1.
Plan Number:	503NDNU0717
Effective Date of this SPD:	July 1, 2020
Original Effective Date of Plan:	July 1, 2017
Funding Method:	Funded through self-insured arrangements
Source of Contributions:	From Notre Dame de Namur University's general assets
Plan Sponsor and Plan Administrator:	Notre Dame de Namur University 1500 Ralston Ave Belmont, CA, 94002 650-508-3651
Plan Sponsor's Employer Identification Number:	94-1156646
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrator:	Marin Benefits Administrators 6366 Commerce Blvd., Suite 293 Rohnert Park, CA 94928 415-526-1401 marinbenefits.com

For additional information regarding the Plan, contact Notre Dame de Namur University at 650-508-3651or refer to the applicable Benefit Documents. Copies of the Benefit Documents are available free of charge from Notre Dame de Namur University or from Marin Benefits Administrators on request.

INTRODUCTION

Establishment and Purpose

Notre Dame de Namur University maintains the Notre Dame de Namur University Self Funded Health Reimbursement Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to its eligible employees and their eligible dependents.

The Plan is provided at no cost to you. The purpose of the Plan is to reimburse you, up to certain limits, for your own and your covered dependents' Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the Plan generally are excludable from your taxable income. Note, however, that you may be required to contribute toward your and your family's coverage under one of Notre Dame de Namur University's integrated group health plans associated with this Plan ("Health Plan.")

This Summary Plan Description ("SPD") is not intended to give any substantive rights to benefits that are not already provided for in the Plan's and its associated integrated group Health Plan's Benefit Documents. Accordingly, if the terms of this SPD conflict with the terms of the Plan-related Benefit Documents, the terms of the Plan-related Benefit Documents will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this SPD with respect to the legal compliance requirements of ERISA and any other federal law, this SPD will control, unless superseded by applicable law.

Eligibility Rules

Please refer to Appendix A of this SPD to determine your eligibility for participating in the Plan.

Eligibility Not Based on Health-Related Factors. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits group health plans from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Eligibility Not Based on Pre-Existing Conditions. The Patient Protection and Affordable Care Act ("ACA") generally prohibits group health plans from denying coverage or excluding specific benefits from coverage due to an individual's pre-existing condition. A pre-existing condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

HRA Participation

Once you become a Participant, the Plan will maintain an HRA Account ("HRA") in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from your associated integrated group Health Plan and any secondary health insurance coverage before any benefits are payable from this Plan.

Enrollment and Elections

Initial Enrollment. You will become a Participant in this Plan by properly and timely completing an enrollment form or enrolling online for coverage under one of Notre Dame de Namur University's integrated group Health Plans. If you do not timely enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

Annual Open Enrollment. You may change your election (or enroll in one of the integrated group Health Plans if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year depending on the policies adopted by Notre Dame de Namur University.

Special Enrollment. You may change your elections regarding the medical plan if you have a special enrollment right and you timely notify Notre Dame de Namur University. See the section called "Special Enrollment and Coverage Rights" below for more information.

Waiver of Participation. If you participate in the Plan, you will be ineligible to make Health Savings Account ("HSA") contributions. You can remove the Plan as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your participation in the Plan before the beginning of that Plan Year. Whether you elect to suspend your coverage is up to you.

You may elect to suspend your participation in the Plan for any future Plan Year by submitting a Waiver of Participation Form to the Plan Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your participation in the Plan for a Plan Year, you agree to permanently forgo reimbursements from the Plan for Medical Care Expenses incurred during that Plan Year, except for certain qualifying dental or vision expenses. Medical Care Expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year.

In lieu of a suspension of your Plan participation, you may elect to permanently opt out of and waive any right to reimbursements from the Plan for expenses incurred after the election takes effect, except for limited-scope dental or vision expenses. The Plan Administrator will offer this opt-out opportunity to you on an annual basis.

Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights

Group health plans must provide special enrollment opportunities to certain employees, dependents, and qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Special enrollment is available in the following situations:

- The acquisition of a new spouse or dependent;
- A loss of other coverage in another group health plan, health insurance, Medicaid, or CHIP; or,
- Becoming eligible for a state premium assistance subsidy.

Special enrollment rights do not apply to "limited scope" dental or vision benefits.

If you or your dependents become eligible for special enrollment and properly enroll in coverage during such special enrollment period, coverage generally will begin no later than the first day of the calendar month following a timely enrollment request. However, if the special enrollment event is the birth of a newborn, or the adoption or placement for adoption of a dependent child, coverage will begin as of the date of birth, adoption, or placement for adoption. Any requests for special enrollment or to obtain more information should be directed to:

Notre Dame de Namur University
Attn: Human Resources
1500 Ralston Ave
Belmont, CA, 94002
650-508-3651

If you decline to enroll during the special enrollment period, you may be required to wait until the Plan's next annual open enrollment period to elect coverage.

Adding a New Spouse or Dependent. If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Loss of Other Coverage in another Group Health Plan, Health Insurance, Medicaid, or CHIP. If you or your dependents were otherwise eligible to enroll in the Plan but declined coverage due to enrollment in another group health plan, health insurance, Medicaid, or Children's Health Insurance Plan ("CHIP"), you may be able to enroll yourself and your dependents in the Plan mid-Plan Year provided that you request coverage within the following timeframes:

- Within 30 days after your or your dependent's other group health/health insurance coverage ends due to a loss of eligibility (or if the other employer ceases to make contributions toward such coverage);
- If your or your dependent's other coverage is COBRA continuation benefits, within 30 days after the exhaustion of the entire applicable COBRA continuation period; or,
- Within 60 days after your or your dependent's Medicaid or CHIP coverage ends due to a loss of eligibility under the applicable program.

Becoming Eligible for a State Premium Assistance Subsidy. If you or your dependents are eligible to enroll in the Plan while simultaneously being eligible to enroll in Medicaid or CHIP, your state of residence may offer a premium assistance program ("PAP") that can help you pay for Plan coverage that would otherwise be unaffordable to you.

Once you or your dependents are accepted into your state's PAP, Notre Dame de Namur University must allow you to enroll in the Plan mid-Plan Year provided that you request coverage within 60 days of being determined eligible by the PAP**.**

The list of states that offer PAPs is updated bi-annually by the Department of Labor ("DOL"). To review the current list of states, go to https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. You also can contact the DOL at www.askebsa.dol.gov or call 1-866-444-EBSA (3272) for more information on Medicaid, CHIP, and PAPs.

Determine Your Medicaid/CHIP Eligibility. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible, contact your state's Medicaid or CHIP office or call 1-877-543-7669 or www.insurekidsnow.gov to find out how to apply, including in the state's PAP (if available).

Coverage Options Available Through the Exchange. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for a PAP, but you may be able to buy affordable individual insurance coverage through a Health Insurance Marketplace ("Exchange"). For more information on the coverage options available to you through the Exchange, go to www.healthcare.gov.

Dependent Coverage under QMCSOs

The Plan may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child in the Plan. You may obtain a copy of Notre Dame de Namur University's procedures governing QMCSO determinations, free of charge, by contacting Notre Dame de Namur University's Human Resources at 650-508-3651.

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a Participant or beneficiary is eligible under the Plan, and that Notre Dame de Namur University determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Continuation of Coverage Rights

See the "Continuation of Coverage Rights" section of this SPD for additional details on a Participant's right to continue certain health care benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

HRA BENEFITS AND ESTABLISHMENT OF ACCOUNTS

Benefits

Please refer to Appendix B of this SPD for details regarding the Plan's benefits, including the allowable benefit maximum available to you for the Plan Year.

Before the start of each Plan Year, Notre Dame de Namur University will determine a maximum annual amount that may be credited during that Plan Year to your HRA. Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses incurred by you, your spouse, or your dependents. Note that your eligible dependents also must be enrolled in one of the integrated group Health Plans in order to be eligible for benefits under this Plan.

Establishment of HRA Accounts

Once you become a Participant, the Plan will maintain an HRA account in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA is merely a recordkeeping account – it is not funded (all reimbursements are paid from the general assets of Notre Dame de Namur University), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from the integrated group Health Plan and any secondary health insurance coverage before any Benefits are payable from this Plan.

Depending on the funding method adopted by Notre Dame de Namur University, the entire annual contribution to your HRA account will be available to you on the first day of the Plan Year or in equal portions throughout the Plan Year, so long as you are covered under the integrated group Health Plan and an Eligible Employee at the time your account is funded.

Debiting HRA Accounts

The Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA. See Appendix B for details on filing a claim for your HRA reimbursement.

The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA as of such date, reduced by any prior reimbursements made to you as of that date.

Forfeiture of Account Balance

Unused amounts in your HRA do not carry over to the next Plan Year. Funds in your HRA are forfeited upon termination of employment or, if earlier, upon loss of eligibility to participate in the Plan. Note, however, that if COBRA continuation coverage is elected upon termination of employment, your health reimbursement account will not be forfeited until the termination of such coverage.

Recovery of Overpayment

You must immediately repay any excess payments or reimbursements paid to you by the Plan in error. You must reimburse Notre Dame de Namur University for any liability Notre Dame de Namur University may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may reduce or suspend any further payments due or future benefits otherwise payable to you under the Plan and may take any other actions as may be permitted by applicable law, including offsetting your salary or wages accordingly.

COVERAGE DURING A LEAVE OF ABSENCE

You may be eligible to continue certain Plan benefits for yourself and your covered dependents for a period of time during a leave of absence, subject to the leave policies and procedures adopted by Notre Dame de Namur University and to the extent prescribed by law. The type of leave you take determines the cost of your benefits (i.e., whether you can continue to pay the same contribution amounts toward your coverage or will need to pay the full premium cost). If you elect not to continue your benefits during your approved leave of absence or if you fail to timely pay for your benefits, your benefits may terminate for the duration of your leave.

Please refer to Notre Dame de Namur University's leave policies and procedures for a description of the different types of leaves of absence available, the maximum length and types of benefits available while on a leave of absence, employee contributions requirements, and the procedures for paying your share of premiums.

Family and Medical Leave Act

In the event Notre Dame de Namur University employs 50 or more individuals within a 75-mile radius, Notre Dame de Namur University will be subject to the Family and Medical Leave Act of 1993 ("FMLA"). FMLA generally allows eligible employees to take a specific amount of job-protected, unpaid leave for certain family and medical reasons specified under the law and its regulations, as amended from time to time.

If you take FMLA leave, you may continue your group health care coverage under the Plan for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave.

- If you substitute accrued paid leave for some of your unpaid FMLA leave days (e.g. both types of leaves run concurrently), your share of premiums will continue to be deducted from your pay (on a pre-tax basis, if applicable).
- If you take an unpaid leave of absence that qualifies under FMLA, you may continue to maintain your health care benefits on the same terms and conditions as though you were still an active employee by paying any normally required contributions for your health care benefits in accordance with Notre Dame de Namur University's FMLA policies and applicable law. If you do not make such payments, or do not make them in a timely manner, your health care coverage may cease. At least 15 days before cessation of your health care coverage, you will be provided with notice of the cancellation. Unless Notre Dame de Namur University has adopted a longer grace period, you will have 15 days from the date of the notice to make the required payment.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments, if applicable. If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections.

If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage. You also may be required to reimburse Notre Dame de Namur University for the cost of coverage provided to you while you were on unpaid FMLA leave (the cost equals the COBRA premium, without a 2% add-on), unless your failure to return to employment is due to a serious health condition, the need to care for a servicemember, or because of other circumstances beyond your control.

For additional information on FMLA leave, and for information on Participant contributions to Plan coverage during FMLA leave, please contact the Plan Administrator.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take a military leave under USERRA, whether for active duty or for training, you are entitled to extend your health care coverage for up to 24 months as long as you give Notre Dame de Namur University advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total

leave, when added to any prior periods of military leave from Notre Dame de Namur University, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated (e.g. you do not elect the extended coverage), when you return to work with Notre Dame de Namur University you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health care coverage under the Plan.

If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. Any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible.

These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Applicable State or Municipal Law

Notre Dame de Namur University shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

CONTINUATION OF COVERAGE RIGHTS

This Plan is bundled with an integrated group Health Plan and is available under COBRA only with the integrated group Health Plan.

Introduction

In the event Notre Dame de Namur University employs 20 or more employees in the preceding year, the following federal COBRA provisions apply to certain health care benefits offered under this Plan. Nothing in this section is intended to expand your rights beyond COBRA's requirements or the requirements of any other applicable federal or state law.

COBRA Coverage is a continuation of the Plan's COBRA-eligible benefits when your coverage would otherwise end due to a life event known as a "qualifying event" (as described below). After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary," which may include you, your spouse, and/or your dependent children. If elected, you must pay the full cost of the COBRA Coverage (including both employer and employee contributions) as described in the "Cost of COBRA Continuation Coverage" section.

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact Notre Dame de Namur University's Human Resources at 650-508-3651.

Other Coverage Options

Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA Coverage. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Qualifying Events for COBRA Coverage

Employee. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA Coverage.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- The employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Dependent Children. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Notifying the Plan of a Qualifying Event

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. However, when the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA Coverage to qualified beneficiaries without notification that such a qualifying event has occurred.

You Must Notify the Plan Administrator of Certain Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify Notre Dame de Namur University 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. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to:

Notre Dame de Namur University
Attn: Human Resources
1500 Ralston Ave
Belmont, CA, 94002
650-508-3651

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

COBRA Coverage Elections

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries who then will have an independent right to elect coverage. Covered employees may elect COBRA Coverage on behalf of their spouses, and parents may elect COBRA Coverage on behalf of their children.

If mailed, your election must be postmarked (or if hand delivered, your election must be received by the individual at the address specified on the election form) no later than 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event (or, if later, 60 days after the date that Plan coverage is lost).

Length of COBRA Coverage

The COBRA Coverage periods described below are maximum coverage periods. COBRA Coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Early Termination of COBRA Coverage" section below.

Employee Coverage. Under COBRA, employees themselves are only eligible for either:

- 18 months of coverage, due to termination of employment or a reduction in hours; or,
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is determined to be disabled by the Social Security Administration before the 60th day of COBRA Coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

COBRA Coverage will be available to the employee and any covered family members. Additionally, under USERRA, covered employees who enlist in the military or are called to active duty may have COBRA-like coverage rights for themselves and their dependents that last for up to 24 months.

Dependent/Qualified Beneficiary Coverage. Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

- 36 months of coverage, due to losing dependent-child status under the plan;
- Up to 36 months of coverage, when the qualifying event is the employee's termination of employment or a reduction in hours and the employee became entitled to Medicare less than 18 months before the qualifying event (where the 36 months is measured from the date the employee became entitled to Medicare); or,
- Up to 36 months of coverage, when there is a second qualifying event during continuation coverage (the death of the covered employee; the divorce or separation of the employee and spouse; the covered employee becoming entitled to Medicare or loss of dependent-child status under the Plan), where the 36 months is measured from the original COBRA Coverage start date.

  These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

Notification Requirement for Extensions. The extension of COBRA Coverage due to a disability or another second qualifying event is available only if you notify Notre Dame de Namur University in writing within 60 days after the qualifying event. You must provide this notice to:

Notre Dame de Namur University
Attn: Human Resources
1500 Ralston Ave
Belmont, CA, 94002
650-508-3651

For the disability extension, the notice must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, to be entitled to a disability extension, you must provide the notice within 18 months after the covered employee's termination of employment or reduction of hours.

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

Continuation of Coverage under California Group Health Policies. COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded plans. The combination of federal and state COBRA coverage may not exceed 36 months in any event. The 36 month period dates back to the original qualifying event. The additional COBRA period of coverage terminates the earliest of:

- The date the maximum period of coverage expires;
- The date coverage ceases because a premium payment is not made on time;
- The date the employer no longer provides any group health plan; or,
- The date the employee or qualified beneficiary moves out of insurer's services area.

Early Termination of COBRA Coverage

COBRA Coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that the you must notify Notre Dame de Namur University in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social

Security Administration to be no longer disabled. Note that you must notify Notre Dame de Namur University in writing within 30 days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;

- Notre Dame de Namur University ceases to provide any COBRA-eligible group health plan coverage for its employees; or,
- For any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving COBRA Coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA Coverage and will most likely increase over time. You will be notified any COBRA premium changes.

Payment for COBRA Coverage. If you elect continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for COBRA Coverage no later than 45 days after the date of your election (this is the date the envelope containing the payment is post-marked, if mailed). **If you do not make your first payment for COBRA Coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan**. You are responsible for making sure that the amount of your first payment is correct and paid in a timely manner.

After you make your first payment for COBRA Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA Coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates**.

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA Coverage will continue for each coverage period if payment for that period is made before the end of the grace period for that payment.

Plan Contact Information

In order to protect your and your dependent's rights, you should keep Notre Dame de Namur University informed of any changes in your address and the addresses of family members.

Golden Gate Parks Conservancy Self Funded Health Reimbursement Plan
Notre Dame de Namur University
1500 Ralston Ave
Belmont, CA, 94002
650-508-3651

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions generally apply to the integrated group Health Plan associated with your HRA. Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

Title VII of the Civil Rights Act of 1964

Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act")

Group health plans and health insurance Issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and Issuers may not, under Federal law, require that a provider obtain authorization from the plan or the Issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, in order to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to provide the Plan with advance notice of services or providers related to the hospital stay. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the medical plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which a mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Affordable Care Act

Certain group health plans have become subject to provisions of the ACA. Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the ACA and all applicable regulations, as may be amended from time to time. Nothing in this section is intended to expand your rights beyond ACA's requirements or the requirements of any other applicable federal or state law.

Patient Protections

Primary Care Provider Designation. If a non-grandfathered group health plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members.

Access to Pediatric Care. If a non-grandfathered group health plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider if such provider participates in the network of the Plan or Issuer.

Access to Obstetrical or Gynecological Care. A participant, regardless of age, shall not need prior authorization from a non-grandfathered group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Emergency Services. A non-grandfathered group health plan that provides emergency services may not require preauthorization for those services. Emergency services must be provided regardless of whether the provider is in- or out-of-network without any time limit within which treatment must be sought.

In addition, the plan generally cannot impose any copayment or coinsurance for out-of-network emergency services that is greater than what would be imposed if the services were provided in-network.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for certain recommended preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual, as recorded by the plan. Updated lists of the preventive services covered under this provision are available at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Mental Health Parity and Addiction Equity

All group health plans that provide both medical and surgical benefits, as well as mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or Issuer must make available to Participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

Under the ACA, group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") requires group health plans to not discriminate based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not

identify the individual. When GINA applies, genetic information is treated as Protected Health Information ("PHI") under HIPAA.

"Genetic information" includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes (essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition).

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures must be followed by Plan Participants to obtain payment of benefits under the Plan, but only to the extent not otherwise provided in the applicable Benefit Documents. If the claims and appeal procedures in this section apply, they shall be construed and applied in a manner consistent with the ACA and the Department of Labor ("DOL") Regulation Section 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

For purposes of this Section, the term "Administrator" means Notre Dame de Namur University or the self-insured plan contract administrator for the Plan.

HRA Reimbursements

The Administrator will act as, or will designate, a claims administrator to decide your claim ("Claimant") in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If the claims administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal for a review of the denied claim. The claims administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by and other applicable law.

Reimbursements under the Plan must be submitted pursuant to procedures established by the claims administrator (see Appendix B for additional details).

Debit Card Payments. Payments from your HRA for qualified Medical Care Expenses will occur automatically if you pay your health care provider using a debit card provided by the claims administrator. You must comply with the card substantiation procedures by providing any requested documentation that supports your reimbursement.

Manual Submissions. In general, a Plan Participant may apply for reimbursement by submitting a request to the claims administrator in such form as the claims administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Medical Care Expense was incurred (or 90 days after the date eligibility ceases). At minimum, the request for reimbursement must include:

- The name of the person or persons who incurred the Medical Care Expenses;
- The nature and date of the expenses so incurred;
- The amount of the requested reimbursement;
- A statement that such expenses have not otherwise been reimbursed and that the Claimant will not seek reimbursement through any other source; and,
- Other such details about the expenses that may be requested by the claims administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Claimant).

The reimbursement request must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such expenses, along with any additional documentation that the claims administrator may request.

Requests for reimbursement should be sent to:

Marin Benefits Administrators
6366 Commerce Blvd., Suite 293
Rohnert Park, CA 94928
Fax paid claim form to (415) 454-2928
Online claim submission: www.marinbenefits.com

Claims Administrator's Procedures

Within 30 days after receipt by the claims administrator of a reimbursement request from Claimant, the claims administrator will reimburse the Claimant for the Medical Care Expenses (if the claims administrator approves the claim), or the claims administrator will notify the Claimant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the claims administrator, including in cases where a reimbursement claim is incomplete. The claims administrator will provide written notice of any

extension, including the reasons for the extension, and will allow the Claimant 45 days in which to complete the previously incomplete reimbursement claim.

If the claims administrator does not fully agree with the claim, the Claimant shall receive an adverse benefit determination ("Adverse Determination"). The Notice of Adverse Determination must be written in a manner calculated to be understood by the Claimant and shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the applicable time limits;
- 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;
- If applicable, specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. Such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) after an appeal.

HRA Claims Appeal Procedures

First Appeal. If the Claimant disagrees with an Adverse Determination, the Claimant or the Claimant's appointed representative may formally request an appeal by following the claims administrator's appeal procedures. The Claimant may appeal any Adverse Determination within 180 days of receipt of such a denial by submitting a written request for review to the Administrator. If the Claimant does not appeal in a timely manner, the Claimant will lose the right to later object to the adverse determination on review ("Appeal Decision").

If the claim on appeal is wholly or partially denied, the claims administrator will provide the Claimant with a written notification of the Plan's Appeal Decision, within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan. Any determination by the claims administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the claims administrator or delegate acted arbitrarily and capriciously. The notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Plan provisions on which the Appeal Decision is based;
- A statement regarding the Claimant's right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about such procedures;
- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and,
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a).

Second Appeal. If specified in the Benefit Documents for the HRA or in documentation given to you by the Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The Appeal Decision with respect to any second appeal will be made within a reasonable period of time, but not later than 30 days after receipt of the second appeal by the Plan.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust the Plan's claims and appeal procedures as a prerequisite to filing a lawsuit for benefits. However, this will not apply if the error was de minimis, if the error does not cause harm to you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of

noncompliance. You may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the \ Plan to be deemed exhausted.

Exhausting Administrative Remedies and Filing Suit

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. **If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD, you may lose the right to file suit in state or federal court.**

A lawsuit seeking benefits under this Plan must be brought within certain time limits as detailed in the "Legal Actions" section of this SPD and in accordance with all applicable laws.

PLAN ADMINISTRATION

In General

Notre Dame de Namur University is the "Plan Administrator" of the Plan and a "Named Fiduciary" within the meaning of such terms under ERISA. Notre Dame de Namur University is the Plan's agent for service of legal process.

Notre Dame de Namur University has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan Participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of Notre Dame de Namur University, furnish to Notre Dame de Namur University such data and information as Notre Dame de Namur University shall require in the performance of its duties under the Plan.

Notre Dame de Namur University may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

Notre Dame de Namur University may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

Notre Dame de Namur University will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Privacy and Security of Information

This Plan is a health plan subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations affecting the maintenance, creation or use of Protected Health Information ("PHI") (as defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Plan Amendment and Termination

Notre Dame de Namur University reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion. For example, Notre Dame de Namur University reserves the right to amend or terminate benefits or covered expenses.. Notre Dame de Namur University also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Notre Dame de Namur University will be done in accordance with Notre Dame de Namur University's normal operating procedures.

STATEMENT OF ERISA RIGHTS

As a Participant in the Notre Dame de Namur University Self Funded Health Reimbursement Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance Issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions 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 employee benefit 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 beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, 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). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

Legal Actions

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of California.

The time limit for bringing any lawsuit that arises under or relates to this Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, you must complete the applicable claims procedure set out in the Plan, as applicable (and comply with all applicable deadlines). If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.
- You must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Right of Reimbursement from Third Parties

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. Accordingly, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount, or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable for you or your dependents under the Plan may not be assigned to anyone. Additionally, to the extent any assignment of benefits is permitted under the Plan, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. As such, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this SPD is a general discussion of the relevant provisions of the Plan found in the official Plan document and Component Plan Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

NOTRE DAME DE NAMUR UNIVERSITY SELF FUNDED HEALTH REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Eligibility

A regular full-time employee of the Employer. A full-time employee is considered to be an individual who is regularly scheduled to work 30 or more hours a week.

If, based on the facts and circumstances on the start date of a new employee, Notre Dame de Namur University determines that such employee is not reasonably expected to be employed an average of at least 30 hours of service per week (or 130 hours of service per month) or is a seasonal employee, then Notre Dame de Namur University shall determine the employee's eligibility or ineligibility for the associated integrated group health plan based on separate rules described in the "Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees" Section of this SPD.

Waiting Period. You are eligible to participate in the Plan with Notre Dame de Namur University on the first day of the month following 30 days from your date of hire.

Effective Date of Coverage. You will commence participation in the Plan on the first day of the month following 30 days from your date of hire.

Dependent Eligibility

Unless specified otherwise under the associated integrated group Health Plan's Benefit Documents, coverage for dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage).

Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions shall have the same meaning set forth in the associated integrated group Health Plan's Benefit Documents which are incorporated by reference herein. Unless otherwise defined in the applicable Benefit Documents, your eligible dependents include:

- Legal Spouse or Domestic Partner of an Eligible Employee;
- Your child(ren) under age 26 (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred before age 26. For purposes of the Plan, a child includes:
  - Your (or your spouse's/domestic partner's) natural child, stepchild, legally adopted child (including any child lawfully placed for adoption with you); and,
  - A child for whom you have court-appointed legal guardianship that is chiefly dependent on you for support and maintenance.
- An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

Cessation of Participation

If you cease to be an eligible employee because you are no longer covered by the integrated group Health Plan, your participation will terminate when your integrated group Health Plan coverage ends.

If you cease to be an eligible employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described in this SPD. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the HRA, provided that you comply with the reimbursement request procedures required under the Plan. Any unused portions will be not be available after termination of employment. However, if you are rehired within 30 days after your termination, your HRA balance will be reinstated.

If your participation terminates, you will receive reimbursement for covered expenses incurred prior to your termination of participation if you apply for reimbursement within 90 days of the date the charges were incurred.

Changes in Family Status

If you change your integrated group Health Plan election from single to family coverage during the Plan Year, the increase in the annual contribution amount will be based on the date the family coverage begins. If you change your integrated group Health Plan election from family to single coverage during the Plan Year, the decrease in the annual contribution amount is applied at the time of the change. If an employee has already exhausted the single contribution amount at the time of the change, reimbursements from the Account will not be permitted for the remainder of the Plan Year.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACA-FT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event Notre Dame de Namur University adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by Notre Dame de Namur University (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from Notre Dame de Namur University's Human Resources Department.

APPENDIX B

NOTRE DAME DE NAMUR UNIVERSITY SELF FUNDED HEALTH REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

Schedule of Benefits

Effective for those meeting the eligibility and waiting period requirements identified in Appendix A.

Health Reimbursement Coverage

- **Benefits Provided.** The Notre Dame de Namur University Self Funded Reimbursement Plan provides reimbursement to participants for certain Medical Care Expenses that are incurred during the Plan Year and not otherwise reimbursed under Notre Dame de Namur University group health plan or another health plan.
- **Health Care Expenses.** Reimbursable Medical Care Expenses are those expenses that are deductible for tax purposes under IRC Section 213 or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses that are not excluded below.
- **Covered Expenses.** The Plan will reimburse up to 100% of the negotiated deductible charges covered by the existing Blue Shield PPO Group Health Plan or Kaiser Group Health Plan. These expenses include eligible deductible charges not reimbursed by another plan. **For Blue Shield: prescription drugs are subject to the Blue Shield deductible and are eligible for payment by this plan.**
- **Excluded Expenses.** The plan specifically excludes coverage for any services not covered by the existing Blue Shield PPO Group Health Plan or Kaiser Group Health Plan and that do not satisfy the plan deductible. **For Kaiser: prescription drug expenses, coinsurance (with the exception of DME) and copayments are not eligible for reimbursement by this HRA Plan.**
- **Maximum Annual Benefit.** The maximum annual benefit for Kaiser participants under this plan is $2000 per single employee, $2000 per member of a family, and $4000 per family. The maximum annual benefit for Blue Shield participants under this plan is $3000 per single employee, $3000 per member of a family, and $6000 per family.

The anniversary date of this plan is July 1 of each year.

Annual enrollment Period is held each year. Only during this period employees may add existing dependents to the plan. Existing dependents added to the plan will be eligible for health plan benefits as of ***July 1***. Newly acquired dependents may be enrolled within 30 days of becoming eligible (ie, marriage, domestic partner, birth, adoption, etc.) and will be eligible for all benefits described herein as of the date of eligibility.

Please consult this booklet for further information regarding the specifics of plan eligibility, dependent coverage and expense reimbursement.

Filing HRA Claims

1. You have received a debit card that has been preloaded with appropriate funds to pay for eligible Kaiser or Blue Shield deductible expenses
2. Submit your Health Reimbursement Claim, paid receipt or bill, along with a completed claim form to:

   Marin Benefits Administrators
   6366 Commerce Blvd., Suite 293
   Rohnert Park, CA 94928

Fax paid claim form to (415) 454-2928
Online claim submission: www.marinbenefits.com

The employee or eligible dependents may submit claims. Payment will be made to the Employee.

3. Claims must be filed within ninety (90) days of the end of the Plan Year or, in the case of dual coverage, date of payment from other plan, to be eligible for reimbursement.
4. Please refer to the Claims and Appeals Procedures later in this SPD for further information.

Health Reimbursement Benefits

After the Employee submits a valid receipt along with a completed claim form, as proof that a Covered Person has incurred covered expenses for care or treatment by an eligible Kaiser or Blue Shield medical services provider, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Claims must be submitted within ninety (90) days of the end of the Plan Year. Amount payable is subject to Coordination of Benefits as applicable.

Eligible Expenses

For charges incurred to be eligible for reimbursement, they must be the result of services provided by a properly licensed individual who is an eligible Kaiser or Blue Shield medical services provider or individual acting under his/her supervision as a technician, and treatment is within the scope of his/her licensure and training.

Medical Care Expenses Exclusions

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to health reimbursement accounts:

- Expenses incurred prior to a Participant's effective date of coverage or after termination of coverage.
- Health insurance premiums for any other plan (including the integrated group Health Plan). Notwithstanding the foregoing, the HRA may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.
- Services which are considered by the Internal Revenue Service to be cosmetic and, therefore, taxable to the Participant.
- Long-term care services.
- Funeral and burial expenses.
- Custodial care.
- Bottled water.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code Section 213(d).

Questions

If you have a question about whether a particular expense is or is not reimbursable under the Plan, you should contact the Plan Administrator. The Plan Administrator has the discretionary authority to determine what expenses are reimbursable, taking into account the terms of this Plan, and rules contained in the applicable sections of the Code, and regulations and other IRS guidance thereunder.

One cautionary note: Benefits for which you receive reimbursement cannot be deducted as a medical expense on your Federal income tax return.

Coordination of Benefits

The purpose of this Plan is to help you meet the cost of needed health care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. Benefits payable by this Plan and any other group medical plan may be coordinated so that the total benefits allowed will not exceed the amount which would have been allowed if no other plan were involved. All benefits provided hereunder are subject to this provision.

This Plan will always pay its regular benefit in full when it is the employee's primary plan. As a secondary Plan, this Plan may provide a reduced amount which, when added to the benefits payable by the other plan, will equal an amount not greater than 100 percent of the fee charged.

Right to Receive and Release Necessary Information

In order to determine this Plan's responsibility, the Employer or Administrator may, with or without notice to you, or without your consent, give to or get from any other plan, company or person any information need to coordinate benefits. When you file a claim with this Plan, you agree to provide, and give the Employer and Administrator your permission to give or get, any additional information needed to coordinate benefits.