UNIVERSITY OF ROCHESTER

CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT

(With Pre-Tax Insurance Premiums)

Plan # 517

SECTION 1
PRELIMINARY MATTERS

1.1 Form. The University of Rochester Cafeteria Plan and Flexible Spending Account is set out in this document, and any amendments hereto. This Plan is a benefit program that is part of the University of Rochester Health Care Plans for Faculty and Staff.

1.2 Purpose. This Plan is maintained for the exclusive benefit of Participants and the sole purpose of this Plan is to provide Qualified Benefits to Participants. It is intended, and shall be interpreted and administered, to comply with Section 125 of the Code whose terms are hereby incorporated by reference.

SECTION 2
DEFINITIONS

2.1 "Account" means an account established to provide a particular Qualified Benefit for a Participant.

2.2 "Affiliate" means a member of the University of Rochester's controlled group as defined in Section 414 of the Code.

2.3 "Claims Administrator" means the person(s) appointed by the Plan Administrator, or any person or persons to whom the Plan Administrator has delegated responsibilities, to serve as Claims Administrator in accordance with Section 6 hereof.

2.4 "Code" means the Internal Revenue Code of 1986, as amended.

2.5 "Contributions" means amounts a Participant contributes to the Plan for a Plan Year.

2.6 "Contribution Election" means an election by a Participant to have Contributions credited to his Account(s) for a Plan Year in accordance with Section 5.

2.7 "Coverage" means Medical or Dental Coverage.

2.8 "Dental Coverage" means group dental coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code.

2.9 "Dependent" means:

A) for purposes of any Coverage listed in Section 2.28(A), a Participant's Spouse, or a Participant's dependent included under the applicable Coverage who qualifies as a Participant's tax dependent as defined in Code Section 152 (as modified by Code Section 105(b) with respect to benefits subject to Code Section 105).

B) for purposes of payment or reimbursement of Health Care Expenses from a Participant's Health Care Expense Account, a Participant's tax dependent as defined in Code Section 152 (as modified by Code Section 105(b)).

C) for purposes of payment or reimbursement of Dependent Care Expenses from a Participant's Dependent Care Expense Account, a Qualifying Individual.

2.10 "Dependent Care Expense" means an expense incurred by a Participant which is an employment-related expense as defined for purposes of Section 21(b) of the Code.

2.11 "Dependent Care Expense Account" means a flexible spending Account established for a Participant under the Plan for reimbursement of Dependent Care Expenses.

2.12 "Effective Date" means the day the Plan begins as set forth under the name of the first Employer listed in Section 2.14. This document reflects the Plan's provisions as it has been restated effective January 1, 2011.

2.13 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if any Employer listed in Section 2.14 is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if any Employer listed in Section 2.14 is a limited liability corporation ("LLC"), any member of the LLC; (iv) if an election is made under the Code for an Employer listed in Section 2.14 to be a Subchapter S corporation, any person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer.

2.14 "Employer" means the Employer and any Affiliated Employer identified below, and their legal successors; provided, however, that as used in Section 6 (Plan

Administration) and Section 7 (Amendment and Termination), "Employer" shall mean only the first employer identified below.

Employer:	University of Rochester
Address:	260 Crittenden Blvd
	Rochester, New York 14642
Effective Date:	January 1, 2006

Affiliated Employer:	N/A
Address:	
Effective Date:	

An Affiliated Employer may discontinue its participation in the Plan by giving advance written notice of the effective date of discontinuance to the Plan Administrator.

2.15 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.16 "Full-Time Employee" is an employee of the Employer who satisfies the criteria below:

- 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 by the college or school concerned.

2.17 "Health Care Expense" means an expense incurred by a Participant for himself, his Spouse or his Dependent for "medical care," as that term is used for purposes of Section 105(b) of the Code, as amended by Section 106(f) of the Code, except that insurance premiums or expenses for long-term care services are not eligible for reimbursement from a Health Care Expense Account.

2.18 "Health Care Expense Account" means a flexible spending Account established for a Participant under the Plan for reimbursement of Health Care Expenses.

2.19 "Highly Compensated Participant" means a Participant who is a highly compensated participant within the meaning of Section 125 of the Code.

2.20 "Key Employee" means a person who is a key employee within the meaning of Section 416 of the Code.

2.21 "Medical Coverage" means group medical coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code.

2.22 "Part-Time Employee" is an employee of the Employer who satisfies the criteria below:

- For hourly, professional, administrative and supervisory: a regular weekly or monthly schedule which is less than the required for full-time status but not less than 17.5 hours per week;

- For faculty: carrying at least half the normal teaching and research load as defined by the college or school concerned.

2.23 "Participant" means an Employee who meets the requirements for participation specified in Section 3.

2.24 "Plan" means this Cafeteria Plan and Flexible Spending Account Plan as set forth in this document and as amended from time to time.

2.25 "Plan Administrator" means the Associate Vice President of Human Resources or other person(s) appointed by the Employer to serve as Plan Administrator in accordance with Section 6 hereof. The Plan Administrator is the "named fiduciary" and "plan administrator" as these terms are used in ERISA.

2.26 "Plan Year" means each 12-consecutive month period beginning January 1 and ending the following December 31.

However, if the Employer terminates the Plan pursuant to Section 7, the last Plan Year shall end on the effective date of termination. If an Affiliated Employer discontinues its participation in the Plan, Participants who are Employees of the Affiliated Employer shall be treated as having participated in the Plan for a short Plan Year ending on the effective date of such discontinuation.

2.27 "Premium" means the premium, or portion thereof, that a Participant is required to pay for his Medical or Dental Coverage. (For purposes of the Plan, "Premium" includes a Participant's cost for any such Coverage that is self-insured by the Employer.)

2.28 "Qualified Benefit" means:

(A) payment of Premiums for any of the Coverage indicated below:

- Medical Coverage
- Dental Coverage

and

(B) payment or reimbursement from the Account(s) indicated below:

- a Participant's Health Care Expense Account for Health Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable from any other source.
- a Participant's Dependent Care Expense Account for Dependent Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable from any other source.

2.29 "Qualifying Individual" means qualifying individual as defined for purposes of Section 21(b) of the Code.

2.30 "Spouse" for purposes of any Coverage listed in Section 2.28(a) means a Participant's legal spouse if recognized by state and federal law covered by the applicable Coverage. For purposes of payment or reimbursement of Eligible Health Care Expenses from a Participant's Health Care Expense Account, "Spouse" means a Participant's legal spouse if recognized by state and federal law.

2.31 "Statutory Leave" means a leave of absence under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act.

SECTION 3
PARTICIPATION

3.1 Eligibility Requirements. An Employee shall be eligible to participate in the Plan if he satisfies the following requirements:

- a regular Full-Time Employee of the Employer or a regular Part-Time Employee of the Employer;

- who is in an eligible employment status as provided in the Summary Plan Description and/or Health Care Program Decision Guide or successor document; and
- who is not making contributions to a Code Section 223 health savings account.

3.2 Participation Date. An eligible Employee shall generally become a Participant in the Plan on the first day of employment, provided he still satisfies the eligibility requirements of Section 3.1 on that date, and has completed and filed all of the forms required for participation by the Plan Administrator. The participation date with respect to each Qualified Benefit may be further restricted by each program, as follows:

- Medical and Dental Coverage: for new hires, participation begins the first day of the month following the hire date, or on the hire date if that occurs on the first of the month. For Employees becoming eligible for benefits under the plan due to a change in status (e.g., those changing from an ineligible to an eligible status, or those being hired by the University who have worked for an Affiliate within the last 30 days), coverage will be effective the first of the month following the date of the appointment (or on the date of the appointment if that occurs on the first of a month), or the first day of the pay period following the date the enrollment form is signed (if submitted before any applicable administrative processing deadline), whichever is later.

- Health Care Expense Account and Dependent Care Expense Account: participation begins the date the enrollment form is completed, or the date of the hire, appointment, or change to eligible status, whichever is later.

In the event of a conflict between the participation date listed above and that in the governing plan document for the specific program, the governing document for that program shall be controlling.

However, no Employee shall be eligible to participate in the Plan until the Effective Date or, in the case of an Employee of an Affiliated Employer, the effective date that Affiliated Employer adopts the Plan, as indicated in Section 2.14.

3.3 Duration of Participation. Except as otherwise provided in this Plan, an Employee shall continue as a Participant so long as he remains an Employee, satisfies the eligibility requirements of this Section 3, makes any required Contributions, and continues to complete and file the forms required for participation by the Plan Administrator.

3.4 Reinstatement of Former Participant. Subject to Sections 4.10(B), 5.3(G) and 5.3(H), a Participant whose employment with the Employer terminates and then resumes shall become a Participant again if and when he again meets the requirements of this Section 3.

SECTION 4
CONTRIBUTIONS AND BENEFITS

4.1 Participant Elections. A Participant may elect to receive his compensation from the Employer in cash, or have a portion thereof credited to his Account(s).

4.2 Maximum Contributions. The Employer or Plan Administrator shall provide advance written notice to each Participant of the minimum and maximum amount of Contributions he can make for a Plan Year (and for each Account), and if the maximum Contribution limit is pro rated for an Employee who is not a Participant during an entire Plan Year (i.e., multiplied by a fraction, the numerator of which is the number of full months of the Plan Year during which he is a Participant, and the denominator of which is the number of full months during the entire Plan Year). Such maximum contributions shall be communicated in the Summary Plan Description and/or Health Care Program Decision Guide or successor document. If a Participant contributes to a Dependent Care Expense Account pursuant to this Plan in addition to a Dependent Care Expense Account pursuant to the plan of an Affiliate, then the Participant's contributions to both such accounts shall be aggregated for purposes of determining whether the Participant has met or exceeded the maximum Contribution amount.

4.3 Credits to Accounts. Contributions shall be credited, through equal payroll deductions, to the Account designated for such Contributions. Subject to the provisions in Section 5 regarding permissible changes to Contribution Elections, the amount credited to an Account for each payroll period shall be the total amount of such Contributions divided by: (i) the number of pay periods in the Plan Year; or (ii) for an Employee who becomes a Participant during the Plan Year, the number of the Participant's pay periods remaining in the Plan Year after he becomes a Participant. Notwithstanding the preceding sentence, except as

provided in Section 4.10(B), Contributions shall cease when an Employee ceases to satisfy the eligibility and participation requirements for the Plan.

4.4 Health Care and Dependent Care Expenses. No Participant shall be entitled to payment or reimbursement for Health Care Expenses or Dependent Care Expenses incurred in any Plan Year unless the expense is incurred on or after the date he became a Participant. Payment or reimbursement for Health Care Expenses and Dependent Care Expenses shall be made at least monthly, provided the Participant files a claim for payment or reimbursement prior to any scheduled cutoff imposed by the Claims Administrator before a scheduled payment/reimbursement date. No Participant shall be entitled to payment or reimbursement for Health Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein. No Participant shall be entitled to payment or reimbursement for Dependent Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein.

The Plan Administrator shall inform Participants of the claims process and also provide them with forms to request payment or reimbursement for Health Care Expenses and Dependent Care Expenses. Such requests shall be accompanied by a copy of the Explanation of Benefits or bill supporting the expense and shall contain the Participant's signed statement that the Health Care Expense or Dependent Care Expense has not been reimbursed, and is not reimbursable, from any other source. The amount credited to a Participant's Health Care Expense and Dependent Care Expense Accounts shall be reduced by the amount paid from such Accounts.

Notwithstanding the above, the Plan Administrator may make arrangements for automatic payment or reimbursement for certain Health Care Expenses and Dependent Care Expenses.

Payment of other Qualified Benefits shall be made automatically.

4.5 Maximum Benefits. The amount available to a Participant for a particular Qualified Benefit shall equal the amount then credited to the Account for that Qualified Benefit Account; provided, however, the amount available for payment or reimbursement for Health Care Expenses incurred during a Plan Year shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Health Care Expenses incurred during the Plan Year.

4.6 Cessation of Contributions. If Contributions to a Participant's Health Care Expense Account cease during a Plan Year, he may submit claims only for

payment or reimbursement of Health Care Expenses incurred before his Contributions cease. All such claims must be submitted within 90 days after the date his Contributions cease. If Contributions to a Participant's Dependent Care Expense Account cease during a Plan Year, he may submit claims only for payment or reimbursement of Dependent Care Expenses incurred for services provided through the end of the Plan Year during which he was a Participant. The amount available for reimbursement for Dependent Care Expenses shall be limited to the amount credited to his Dependent Care Expense Account.

4.7 Forfeitability of Benefits. Except as provided in Section 4.8 below, if total Contributions to a Participant's Account exceed the Qualified Benefits paid from that Account for the Plan Year, the Participant shall forfeit the excess Contributions.

4.8 No Grace Period. The Plan does not provide for the grace period provisions permitted in accordance with IRS Notice 2005-42.

4.9 Continuation During Leaves of Absence. The Plan Administrator or Employer will advise any Employee who is eligible for a Statutory Leave of his right to maintain Coverage during the Statutory Leave, and his specific rights and obligations if he chooses to continue such Coverage during the Statutory Leave. The Plan Administrator or Employer shall advise each Employee who takes any other type of leave of absence of his right, if any, to maintain such Coverage in effect during the period of leave, and the Employer's right, if any, to recover the amount of Contributions paid by the Employer on behalf of the Employee during the leave period. Such provisions shall be contained in the Summary Plan Description and/or the University of Rochester Health Care Program Decision Guide or successor document.

4.10 Termination of Employment. If a person ceases to be a Participant during a Plan Year, he shall be eligible to receive Qualified Benefits incurred on or prior to the date he ceases participation; provided, however, that claims for Health Care Expenses and Dependent Care Expenses are subject to the following rules. These rules shall also apply if a Participant ceases to be an eligible Participant due to termination of employment with the Employer, even if the Participant remains or becomes employed by an Affiliate, if that Affiliate is not an Affiliated Employer participating in this Plan.

A) If a Participant's employment terminates during the Plan Year, he may submit claims only for payment or reimbursement of Dependent Care Expenses incurred for services provided through the end of the Plan Year during which he was a Participant. The amount available for reimbursement for Dependent Care Expenses shall be limited to the amount

credited to his Dependent Care Expense Account. All such claims must be filed no later than the April 30th following the end of the Plan Year

B) If a Participant's employment terminates during the Plan Year and he is entitled to continue Contributions to his Health Care Expense Account through the end of that Plan Year pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), he may make after-tax contributions to such Account for that period. If the Participant makes such election, he may submit claims for payment or reimbursement of Health Care Expenses incurred: (i) through the end of the Plan Year in which his employment terminated; or (ii) if earlier, the date his after-tax contributions cease. The amount available for payment or reimbursement of such Health Care Expenses shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Health Care Expenses incurred during the Plan Year. If the Participant does not make such election, or makes such election but ceases after-tax contributions prior to the end of the Plan Year: (i) he may submit claims only for payment or reimbursement of Health Care Expenses incurred prior to his termination or the date his after-tax contributions ceased; (ii) all such claims must be submitted within 90 days following the date his employment terminated or the date his after-tax contributions ceased; and (iii) he shall forfeit any amount remaining in his Health Care Expense Account after payment of claims filed before or within such 90 day period.

4.11 COBRA Health Continuation Coverage. The Employer or its designee shall advise each Participant, his Spouse and Dependents of any rights he may have to continued health insurance coverage to continue Contributions to his Health Care Expense Account pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

4.12 Specific Benefits. The specific benefits to which a Participant, his Dependent or beneficiary may be entitled under his Medical or Dental Coverage shall be as determined under the applicable plan, program, insurance policy or contract providing such Coverage. The Employer does not guarantee payment of any benefits that may be payable under an insurance policy or contract, and eligibility under this Plan does not guarantee that Participants will satisfy any insurer's requirements for such Coverage.

4.13 Changes in Premiums. The Employer or Plan Administrator shall provide advance written notice to each Participant of the Premiums in effect at the beginning of each Plan Year, and any changes in Premiums during the Plan Year.

4.14 Statement of Benefits. By January 31st, each Participant will receive a W-2 Wage and Tax Statement showing the amount of his Contributions to his Dependent Care Expense Account for the previous calendar year.

4.15 Experience Gains. Any amounts forfeited by Participants from Health Care Expense Accounts or Dependent Care Expense Accounts in accordance with Section 4.7 hereof, may be:

A) In the case of forfeitures from Dependent Care Expense Accounts only, retained by the Employer;

B) If not retained by the Employer, or in the case of Health Care Expense Accounts, may be used only in one or more of the following ways:

1) to reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis, as described in Prop. Treas. Reg. § 1.125-5(o)(2) (or successor regulations);

2) returned to employees on a reasonable and uniform basis, as described in Prop. Treas. Reg. § 1.125-5(o)(2) (or successor regulations);

3) to defray expenses to administer the plan; or

4) any other purpose permitted by Prop. Treas. Reg. § 1.125-5(o) (or successor regulations).

SECTION 5
ELECTION PROCEDURES

5.1 Annual Elections. Before the beginning of each Plan Year, the Plan Administrator shall provide one or more election forms (written or in electronic form) to each Employee eligible to participate in the Plan that Plan Year. Employees who become eligible to participate in the Plan during the Plan Year shall be provided with election form(s) during the month in which they meet the eligibility requirements. The completed form(s) shall indicate the Contributions to be credited to the Account for each Qualified Benefit. Election form(s) for a Plan Year must be completed and filed with the Employer on or before the date specified by the Plan Administrator. A Participant's failure to submit election form(s) by the specified date shall be deemed an election to not make any Contributions for the Plan Year.

Notwithstanding the above, at the times described above, the Employer may instead notify each Employee who is eligible to participate in the Plan that his Premium for Medical or Dental Coverage shall automatically be paid through Contributions to the Plan, unless the Employee elects otherwise in writing signed by the Employee and filed with the Plan Administrator. An Employee's failure to make such an election shall be deemed an election to participate in and make such Contributions to the Plan.

5.2 Irrevocability of Elections. Once a Participant makes his Contribution Elections for a Plan Year and the Plan Year commences, the Contribution Elections shall be irrevocable for the entire Plan Year, except as provided in Section 5.3.

5.3 Changes in Status. Participants may prospectively revoke their Contribution Elections and make new Contribution Elections for a Plan Year in accordance with the provisions of this Section. This Section shall be interpreted in a manner consistent with Section 125 of the Code and other guidance issued thereunder.

A) Health Plan Special Enrollment Rights. Contribution Elections for Medical and Dental Coverage may be changed in a manner consistent with the exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996, as amended.

B) COBRA Coverage. If a Participant, his Spouse or Dependent child becomes eligible for continuation coverage under the Consolidated Omnibus Reconciliation Act of 1985 as amended (or similar state law) under a group health plan of the Employer, the Participant may increase his Contribution Elections for Medical or Dental Premiums to pay for the continuation coverage.

C) Court Judgment, Decree or Order. A Participant's Contribution Election for Medical or Dental Coverage may be increased to pay for a Dependent child's or foster child's Medical or Dental Coverage as required under a court order or state agency notice resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined under Section 609 of ERISA). Similarly, Contribution Elections may be reduced to reflect any decrease in Medical or Dental Coverage Premiums if such judgment, decree or order requires someone else to provide such Coverage for such child. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Election for his Health Care Expense Account may also be increased or reduced in a manner consistent with such court judgment, decree or order.

D) Entitlement to Medicaid. A Contribution Election for Medical Coverage Premiums may be reduced if the Participant, his Spouse or Dependent

becomes entitled to Medicaid coverage (other than only the program for distribution of pediatric vaccines). A Participant's Contribution Election for Medical Premiums may be increased if the Participant, his Spouse or Dependent loses such Medicaid eligibility. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Elections for his Dental and Vision Premiums and a Participant's Contribution Election for his Health Care Expense Account may also be reduced or increased when the Participant, his Spouse or Dependent becomes entitled to, or loses, such Medicaid eligibility.

E) Loss of Qualifying Individual Status. A Participant's Contribution Election for his Dependent Care Expense Account may be changed in a manner consistent with a change in the status of an individual as a Qualifying Individual.

F) Other Changes in Status. Contribution Elections may change on account of and in a manner consistent with a change in: (i) the Participant's legal marital status (including: marriage, divorce, death of a spouse, legal separation, or annulment); (ii) the number of the Participant's Dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child); (iii) the employment status of the Participant, his Spouse or Dependent resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes the Participant, his Spouse or Dependent to become eligible, or cease to be eligible, for Coverage under this Plan or other employer plan providing Qualified Benefits; (iv) a Dependent's eligibility for Medical or Dental Coverage due to age, student status, marriage or similar circumstance; (v) any other change considered to be a change in status under Section 125 of the Code and regulations thereunder that is listed in the Summary Plan Description and/or Health Care Program Decision Guide or successor document.

G) Special Rule for Termination of Employment. Notwithstanding Section 5.3(F), but subject to Section 5.3(H), if a Participant's employment with the Employer terminates and then resumes in the same Plan Year within a period of 30 days or less, his Contribution Elections in effect before termination shall automatically be reinstated upon resumption of employment, unless some other intervening event has occurred that would permit a change to one or more Contribution Elections. If the Participant terminates employment with an Affiliate that does not participate in the Plan, and is hired by the University within 30 days or less, then the hire

shall be treated as a change in worksite, and the Participant may enroll consistent with Section 5.3 (F).

H) Special Rules for Statutory Leave. If a Participant takes a Statutory Leave, the Participant may (i) revoke his Contribution Elections at the beginning of the Statutory Leave and make new Contribution Elections at the end of the Statutory Leave; or (ii) keep his Contribution Elections in place and make contributions during the leave as follows:

a) continue to pay the Employee's share of Contributions with after-tax payments during the Statutory Leave, or to the extent the employee continues receiving pay during the leave, with pre-tax contributions taken from such taxable income; or

b) the Employer may elect to pay the Employee's share of Contributions during a Statutory Leave and recover the cost of these payments through pre-tax payroll deductions after the Statutory Leave if the Employer does so for all Participants on the same type of Statutory Leave, except that the Employer will not make the Employee's elective contributions to a Health Care Expense Account or Dependent Care Expense Account.

A Participant shall not be eligible for reimbursement for Health Care Expenses or Dependent Care Expenses incurred during a period in which Contributions cease as a result of a Statutory Leave.

The maximum period that the employee will be allowed to continue participation pursuant to this provision is for the duration of Statutory Leave under the Family and Medical Leave Act (generally up to 12 weeks, or up to 26 weeks if the leave reason is taken to care for an injured or ill covered servicemember), and for up to 12 months if the leave is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Participants who remain on leave after exhausting such maximum period, may elect COBRA continuation coverage (see Section 4.10) or, in the case of USERRA leave, continuation coverage for up to 24 months from the date the leave began in accordance with the regulations promulgated pursuant USERRA, if those provision are more favorable to the Participant.

I) Change in Premium. If Participants' Premium for Medical or Dental Coverage changes during a Plan Year, there shall be an automatic corresponding change to the Participants' Contributions for Medical and/or Dental Premiums.

J) Change in Dependent Care Expense. If there is a change in a Participant's dependent care provider or in the dependent care provider's cost for services, the Participant may make a corresponding change to his Contribution Election for his Dependent Care Expense Account (provided that, in the case of a change in a dependent care provider's cost for services, the dependent care provider is not a qualifying child or qualifying relative of the Participant within the meaning of Sections 152(a) of the Code.

K) Change in Coverage Options. If a Medical or Dental option is added, the Contribution Election for Medical or Dental Premiums for a Participant who elects the new Coverage option shall be changed to correspond to the Participant's Premium for that Coverage. If a Medical or Dental Coverage option is eliminated, the Contribution Election for Medical or Dental or Premiums for an affected Participant shall be changed to conform to the change in the Participant's Premium for Coverage.

L) Change in Coverage under Other Employer's Plan. A Participant may change his Contribution Elections (other than his Contribution for his Health Care Expense Account) under this Plan in a manner consistent with a change by his Spouse, former Spouse or Dependent under another plan providing Qualified Benefits if the change under such other plan (i) is permitted under the Sections above; or (ii) is made for the normal election period under such other plan and that period is different from the Plan Year of this Plan.

M) Loss of Other Group Health Coverage. A Participant may increase his Contribution Election for Medical or Dental Premiums under this Plan if the Participant, his Spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan, through no fault of his own.

5.4 Limits on Contribution Election Changes. Contribution Election changes must be made within 30 days after a change in status event listed in Section 5.3, except that Participants experiencing a HIPAA special enrollment right in connection with losing eligibility for, or becoming eligible for premium assistance under, Medicaid or Child Health Insurance Program, must make election changes within 60 days after the event. Such election changes shall be effective at the time prescribed by the Plan Administrator in the Summary Plan Description. A Participant who changes his Contribution Election for his Health Care Expense Account during a

Plan Year may not reduce his elected amount below the amount of Health Care Expenses submitted for reimbursement during the Plan Year.

5.5 Nondiscrimination Requirements. The Plan Administrator may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable nondiscrimination requirements and all applicable limitations on Qualified Benefits provided to Highly Compensated Participants and Key Employees. These actions include the reduction of Contributions made by Highly Compensated Participants or Key Employees, based on a uniform and consistent method applicable to all Highly Compensated Participants or Key Employees.

For purposes of the applicable Code nondiscrimination requirements, this Plan and the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums) shall be considered a single plan.

SECTION 6
PLAN ADMINISTRATION

6.1 Plan Administrator. The Associate Vice President of Human Resources shall be the Plan Administrator. The Employer reserves the right to appoint a different Plan Administrator and/or designate one or more other persons, including an insurance company or third party administrator, to carry out some or all of the duties under the Plan.

6.2 Powers. The Plan Administrator has full authority and responsibility to control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan (but not to modify or amend the Plan) and to decide any and all questions arising in the administration, interpretation, and application of the Plan. The Plan Administrator shall establish whatever rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of the Plan Administrator or its action with respect to the Plan shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the Plan.

6.3 Delegation of Responsibilities. The Plan Administrator may delegate any of his duties or responsibilities to other persons. Any such allocation or delegation of responsibilities shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated.

6.4 Agents and Contractors. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may employ, with the approval of the Plan Administrator, one or more accountants, legal counsel or other persons as shall be deemed necessary for the effective control and management of the operation and administration of the Plan. The Plan Administrator, the Employer and its officers and trustees, and any person to whom any duty or responsibility has been delegated by the Plan Administrator shall be entitled to rely upon all tables, certificates, opinions and reports furnished by any duly appointed accountant, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, certificates, opinions or reports.

6.5 Claims Administrator. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may, with the approval of the Plan Administrator, by written instrument appoint an insurance company, third party administrator or other party to act as Claims Administrator, to act as the claims fiduciary to construe the terms of the Plan and trust and determine eligibility for benefits, process claims under the Plan, and to carry out any and all of the Plan Administrator's administrative duties under the Plan to the extent specified in such instrument.

6.6 Expenses. The Plan Administrator shall not receive any compensation from the Plan for his services, but the Employer may pay the Plan Administrator a salary and the Plan may reimburse the Plan Administrator for any necessary expenses incurred.

6.7 Records. The Plan Administrator and his designees shall maintain records showing the fiscal transactions of the Plan.

6.8 Indemnification. To the extent not covered by insurance, the Employer will indemnify the Plan Administrator and any employee of the Employer acting on the Plan Administrator's behalf, against all claims, loss, damages, expenses and liability arising from any action or failure to act under the Program to the fullest extent permitted under the law and the Employer's governing rules.

6.10 Claims Procedures. Qualified Benefits shall be paid in accordance with the terms of the Plan. A Participant who disagrees with a decision concerning his right to participate in the Plan or wishes to make a claim for a Qualified Benefit may file a claim in writing. The Employer, the Plan Administrator and/or the Claims Administrator shall establish and maintain claims procedures in accordance with ERISA, which shall include: (i) a procedure for advising claimants on how to make claims for benefits; (ii) a procedure for the review of such claims and giving timely written notice to the claimant concerning the determination made on the

claim; and (iii) a procedure for requesting a review of any claim that is denied in whole or part and giving timely written notice to the claimant concerning the decision on review.

Claims regarding eligibility for participation should be submitted in accordance with the procedures outlined in Exhibit B to the University of Rochester Welfare Benefits Wrap Plan Document. All claims for benefits under a Program shall be submitted to the appropriate Claims Administrator in accordance with the terms of that Program and shall be subject to the claims review procedure for that Program.

Any claim for payment or reimbursement for Health Care Expenses or Dependent Care Expenses incurred in a Plan Year must be filed with the applicable Claims Administrator no later than the April 30th following the end of the Plan Year, or in the case of the Health Care Expense Account 90 days after he ceases participation in the Plan if earlier, or any earlier date specified in the Plan. Any other claim related to the Health Care Expense Account or Dependent Care Expense Account must be filed no later than the April 30th following the end of the Plan Year to which the Qualified Benefit relates, or if earlier 90 days after he ceases participation in the Plan in the case of the Health Care Expense Account, or any earlier date specified in the Plan.

6.11 Qualified Reservist Distributions. Notwithstanding any other provision of the Plan, a "Qualified Reservist" (as described below) may request and receive a distribution from his Health Care Expense Account (a "Qualified Reservist Distribution") in accordance with the following provisions.

A) A Qualified Reservist is an Employee who, by reason of being a member of a reserve component, is ordered or called to active duty for a period beginning or continuing after June 18, 2008 and which is either an indefinite period or is for 180 days or more (without regard to whether the actual period of active duty is less than 180 days or is otherwise changed). For purposes of this provision:

1) "reserve component" means the Army National Guard of the United States, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of the United States, the Air Force Reserve, Coast Guard Reserve, or Reserve Corps of the Public Health Service;

2) an initial order or call to active duty and any subsequent order(s) or call(s) to duty extending the initial order or call to active duty shall be aggregated when determining if the 180 day requirement above is satisfied; and

3) the Employer may rely on the order(s) or call(s) to determine the period an Employee has been ordered or called to active duty.

B) To receive a Qualified Reservist Distribution, a Qualified Reservist must first:

1) provide the Employer with a copy of his order(s) or call(s) to active duty; and

2) request the Qualified Reservist Distribution by completing and filing with the Employer a request form (available from the Employer) no earlier than the date of his order or call to active duty and no later than the last day of the Plan Year that includes the date of his order or call to active duty.

C) The maximum amount available for a Qualified Reservist Distribution shall equal: (i) the Employee's total pre-tax salary reduction Contributions made to his Health Care Expense Account for the Plan Year that includes the date of his order or call to active duty (determined as of the date of his Qualified Reservist Distribution request); minus (ii) the amount distributed from his Health Care Expense Account for Eligible Health Care Expenses incurred during that Plan Year (determined as of the date of his Qualified Reservist Distribution request).

D) In no event shall the amount available for a Qualified Reservist Distribution include any amount attributable to Contributions to the Employee's Health Care Expense Account which are for a Plan Year ended on or before January 1, 2009 or for a Plan Year which ended before his order or call to active duty.

E) The Employer shall pay a Qualified Reservist Distribution to the Employee within a reasonable time, but not more than sixty (60) days after the Employee's request for the Qualified Reservist Distribution.

F) An Employee may receive only one Qualified Reservist Distribution during the same Plan Year.

G) Any Employee who receives a Qualified Reservist Distribution may continue to submit claims for Eligible Health Care Expenses incurred before the date he requests the Qualified Reservist Distribution, and such claims shall be processed and paid in accordance with the terms of the Plan. The amount available to pay such claims shall equal the amount of his Contribution Election for Health Care Expenses for the Plan Year in which he requests the Qualified Reservist Distribution, minus (i) the total amount

of Eligible Health Care Expenses paid or reimbursed from his Health Care Expense Account prior to the date he requests the Qualified Reservist Distribution, and (ii) the amount of the Qualified Reservist Distribution.

H) An Employee who receives a Qualified Reservist Distribution may submit claims for Eligible Health Care Expenses incurred after the date he requests the Qualified Reservist Distribution only if he is entitled and elects to continue participation in the Plan by making contributions after such date pursuant to the provisions of Section 5.3H of this Plan, and/or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and/or the Uniformed Services Employment and Reemployment Rights Act (USERRA); provided, however, if his contributions cease prior to the end of a Plan Year: (i) he may submit claims only for payment or reimbursement of Eligible Health Care Expenses incurred between the beginning of that Plan Year and the date his contributions cease; (ii) all such claims must be submitted within 90 days following the date his contributions cease; and (iii) he shall forfeit any amount remaining in his Health Care Expense Account after payment of claims filed before or within such 90 day period. Claims for Eligible Health Care Expenses incurred after the date he requests the Qualified Reservist Distribution shall be processed and paid in accordance with the terms of the Plan. The amount available to pay any claim incurred during the Plan Year in which he requests the Qualified Reservist Distribution shall equal the amount of his Contribution Election for Health Care Expenses for that Plan Year, minus (i) the total amount of Eligible Health Care Expenses incurred during that Plan Year and paid or reimbursed from his Health Care Expense Account prior to the date of the claim, and (ii) the amount of the Qualified Reservist Distribution.

I) Qualified Reservist Distributions shall be uniformly available to all Participants who are Qualified Reservists.

J) Qualified Reservist Distributions shall be included in the gross income of the Employees who receive them and reported by the Employer as wages.

K) This Subsection shall be interpreted and applied in a manner consistent with IRS Notice 2008-82 and Treasury Regulations and other Internal Revenue Service guidance regarding Qualified Reservist Distributions.

SECTION 7
AMENDMENT AND TERMINATION OF THE PLAN

7.1 Amendment and Termination. The Employer and the Senior Vice President of Administration and Finance shall have the right to amend this document and the terms of the Plan at any time, including the right to terminate this Plan at any time. The right to amend or modify the Plan includes the right to change the benefits and cost sharing provisions under the Plan. Any amendment shall be in writing and shall be effective only for periods after the later of its adoption date or effective date.

SECTION 8
HIPAA PRIVACY RULES

8.1 Refer to University of Rochester Welfare Wrap Plan. Each "Health Plan", as such term is defined in 45 C.F.R. 160.103 will use and/or disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"), and in accordance with the Privacy Rules outlined in the plan document for the University of Rochester Welfare Wrap Plan, which are hereby incorporated by reference.

SECTION 9
MISCELLANEOUS

9.1 No Employment Rights Conferred. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the employment of any person. Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate his employment with the Employer at any time.

9.2 No Compensation for Other Purposes. Qualified Benefits paid under the terms of this Plan shall not be treated as additional compensation to the Participant for purposes of determining Contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer unless otherwise provided under the terms of the retirement plan or other benefit program.

9.3 General Assets. Payment of Qualified Benefits shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no trust fund for payment of Qualified Benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609 of ERISA), and except to the extent that this provision may be contrary to other law, Qualified Benefits payable from the Plan shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.

9.4 Impossibility of Performance. In the event that it becomes impossible for the Employer to perform any act under the Plan, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the Plan.

9.5 Gender. For purposes of this Plan, unless the context requires otherwise, whenever the masculine gender is used, it shall also be deemed to include the feminine gender.

9.6 Governing Law. All legal questions pertaining to the Plan shall be determined in accordance with the laws of the State of New York except when those laws are preempted by the laws of the United States.

By signing this instrument, the Employer(s) approves and adopts the terms of the Flexible Spending Account Plan as stated herein.

University of Rochester	N/A
(Employer Name)	(Affiliated Employer Name)
By: [signature]	By:
Print Name: Charles J Murphy	Print Name:
Title: AVP for HR	Title:
Date: 8/16/12	Date:

UNIVERSITY OF ROCHESTER

CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT

(With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums)

Plan # 517

SECTION 1
PRELIMINARY MATTERS

1.1 Form. The University of Rochester Cafeteria Plan and Flexible Spending Account is set out in this document, and any amendments hereto. This Plan is a benefit program that is part of the University of Rochester Health Care Plans for Faculty and Staff.

1.2 Purpose. This Plan is maintained for the exclusive benefit of Participants and the sole purpose of this Plan is to provide Qualified Benefits to Participants. It is intended, and shall be interpreted and administered, to comply with Section 125 of the Code whose terms are hereby incorporated by reference.

SECTION 2
DEFINITIONS

2.1 "Account" means an account established to provide a particular Qualified Benefit for a Participant.

2.2 "Affiliate" means a member of the University of Rochester's controlled group as defined in Section 414 of the Code.

2.3 "Claims Administrator" means the person(s) appointed by the Plan Administrator, or any person or persons to whom the Plan Administrator has delegated responsibilities, to serve as Claims Administrator in accordance with Section 6 hereof.

2.4 "Code" means the Internal Revenue Code of 1986, as amended.

2.5 "Contributions" means amounts a Participant contributes to the Plan for a Plan Year.

2.6 "Contribution Election" means an election by a Participant to have Contributions credited to his Account(s) for a Plan Year in accordance with Section 5.

2.7 "Coverage" means Dental and/or High Deductible Health Coverage.

2.8 "Dental Care Expense" means an expense for dental care: (i) which constitutes "medical care" as that term is used for purposes of Section 105(b) of the Code (including non-prescription or "over-the-counter" expenses not allowable as a deduction under Section 213 of the Code, except as prohibited by Code Section 106(f)); (ii) coverage for which is "permitted coverage" within the meaning of Section 223 of the Code, and regulations and guidance issued thereunder; and (iii)

is incurred by a Participant for himself or a person who, at the time the expense is incurred, is his Spouse or Dependent.

2.9 "Dental Coverage" means group dental coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which: satisfies the requirements of Sections 105 and 106 of the Code; and (ii) is "permitted coverage" within the meaning of Section 223 of the Code, and regulations and guidance issued thereunder.

2.10 "Dependent" means:

A) for purposes of any Coverage listed in Section 2.33(A), a Participant's Spouse, or a Participant's dependent included under the applicable Coverage who qualifies as a Participant's tax dependent as defined in Code Section 152 (as modified by Code Section 105(b) with respect to benefits subject to Code Section 105).

B) for purposes of payment or reimbursement of Health Care Expenses from a Participant's Health Care Expense Account, a Participant's tax dependent as defined in Code Section 152 (as modified by Code Section 105(b)).

C) for purposes of payment or reimbursement of Dependent Care Expenses from a Participant's Dependent Care Expense Account, a Qualifying Individual.

D) for purposes of the Health Savings Account, the definition in the documents provided by the HSA trustee/custodian.

2.11 "Dependent Care Expense" means an expense incurred by a Participant which is an employment-related expense as defined for purposes of Section 21(b) of the Code.

2.12 "Dependent Care Expense Account" means a flexible spending Account established for a Participant under the Plan for reimbursement of Dependent Care Expenses.

2.13 "Effective Date" means the day the Plan begins as set forth under the name of the first Employer listed in Section 2.16. This document reflects the Plan's provisions as it has been restated effective January 1, 2011.

2.14 "Eligible Health Care Expense" means a Dental Care Expense, Vision Care Expense, Preventive Care Expense, or other Post-Deductible Expense. Eligible Health Care Expenses do not include expenses that are ineligible for

reimbursement in accordance with Code Section 106(f), nor do they include insurance premiums or expenses for long-term care services.

2.15 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if any Employer listed in Section 2.16 is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if any Employer listed in Section 2.16 is a limited liability corporation ("LLC"), any member of the LLC; (iv) if an election is made under the Code for any Employer listed in Section 2.16 to be a Subchapter S corporation, and person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer.

2.16 "Employer" means the Employer and any Affiliated Employer identified below, and their legal successors; provided, however, that as used in Section 6 (Plan Administration) and Section 7 (Amendment and Termination), "Employer" shall mean only the first Employer identified below.

Employer: University of Rochester

Address: 260 Crittenden Blvd.
Rochester, New York 14642

Effective Date: January 1, 2008

Affiliated Employer: N/A

Address: ____________

Effective Date: ____________

An Affiliated Employer may discontinue its participation in this Plan by giving advance written notice of the effective date of discontinuance to the Plan Administrator.

2.17 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.18 "Full-Time Employee" is an employee of the Employer who satisfies the criteria below:

- 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 by the college or school concerned.

2.19 "Health Care Expense Account" means a limited-purpose and post-deductible flexible spending Account established for a Participant under the Plan for reimbursement of Eligible Health Care Expenses.

2.20 "Health Savings Account" or "HSA" means an Internal Revenue Code Section 223 Account owned by a Participant who is enrolled in an HSA-eligible High Deductible Health Plan, which is used to pay for current and future qualified medical expenses. Such accounts are established and maintained outside of the Plan with the Employee's HSA trustee/custodian.

2.21 "Highly Compensated Participant" means a Participant who is a highly compensated participant within the meaning of Section 125 of the Code.

2.22 "High Deductible Health Coverage" means coverage under a group term health plan maintained for Employees by the Employer under a separate plan, program, insurance policy or contract and which: (i) satisfies the requirements of Sections 105 and 106 of the Code; and (ii) qualifies as a high deductible health plan as described in Section 223 of the Code and regulations and guidance issued thereunder.

2.23 "Key Employee" means a person who is a key employee within the meaning of Section 416 of the Code.

2.24 "Minimum Annual Deductible Amount" means the minimum annual deductible amount applicable to a Participant under a high deductible health plan, as determined under Section 223 of the Code and regulations and guidance issued thereunder.

2.25 "Part-Time Employee" is an employee of the Employer who satisfies the criteria below:

- For hourly, professional, administrative and supervisory: a regular weekly or monthly schedule which is less than the required for full-time status but not less than 17.5 hours per week;

- For faculty: carrying at least half the normal teaching and research load as defined by the college or school concerned.

2.26 "Participant" means an Employee who meets the requirements for participation specified in Section 3.

2.27 "Plan" means this Cafeteria Plan and Flexible Spending Account Plan as set forth in this document and as amended from time to time.

2.28 "Plan Administrator" means the Associate Vice President of Human Resources or other person(s) appointed by the Employer to serve as Plan Administrator in accordance with Section 6 hereof. The Plan Administrator is the "named fiduciary" and "plan administrator" as these terms are used in ERISA.

2.29 "Plan Year" means the period beginning on the Effective Date and ending on December 31, 2008 and, thereafter, the twelve consecutive month period ending on the same date.

However, if the Employer terminates the Plan pursuant to Section 7, the last Plan Year shall end on the effective date of termination. If an Affiliated Employer discontinues its participation in the Plan, Participants who are Employees of the Affiliated Employer shall be treated as having participated in the Plan for a short Plan Year ending on the effective date of such discontinuation.

2.30 "Post-Deductible Expense" means an expense: (i) which constitutes "medical care" as that term is used for purposes of Section 105(b) of the Code (including non-prescription or "over-the-counter" expenses not allowable as a deduction under Section 213 of the Code, except as prohibited by Code Section 106(f)); (ii) is incurred during a year by a Participant for himself or a person who, at the time the expense is incurred, is his Spouse or Dependent; and (iii) is incurred after the Participant satisfies his Minimum Annual Deductible Amount for that year.

2.31 "Premium" means the premium, or portion thereof, that a Participant is required to pay for his Dental and/or High Deductible Health Coverage. (For purposes of the Plan, "Premium" includes a Participant's cost for any such Coverage that is self-insured by the Employer.)

2.32 "Preventive Care Expense" means an expense for preventive care: (i) which constitutes "medical care" as that term is used for purposes of Section 105(b) of the Code (including non-prescription or "over-the-counter" expenses not allowable

as a deduction under Section 213 of the Code, except as prohibited by Code Section 106(f)); (ii) coverage for which is "permitted coverage" within the meaning of Section 223 of the Code, and regulations and guidance issued thereunder; and (iii) is incurred by a Participant for himself or a person who, at the time the expense is incurred, is his Spouse or Dependent.

2.33 "Qualified Benefit" means:

(A) payment of Premiums for any of the other Coverage indicated below:

- Dental Coverage
- High Deductible Health Coverage

and

(B) payment or reimbursement from the Account(s) indicated below:

- a Participant's Health Care Expense Account for Eligible Health Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable under any Dental, High Deductible Health, or Vision Coverage, or from any other coverage or other source.
- a Participant's Dependent Care Expense Account for Dependent Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable from any other source.

(C) Contributions to a Participant's Health Savings Account for qualified medical expenses, but only to the extent the Participant is enrolled in an HSA-eligible High Deductible Health Plan and meets the other criteria for participation in an has, if the Employer has a established a relationship with the HSA trustee/custodian to enable HSA contributions through payroll deduction.

2.34 "Qualifying Individual" means qualifying individual as defined for purposes of Section 21(b) of the Code.

2.35 "Spouse" for purposes of any Coverage indicated in Section 2.33(a) means a Participant's legal spouse if recognized by state and federal law covered by the applicable Coverage. For purposes of payment or reimbursement of Eligible Health Care Expenses from a Participant's Health Care Expense Account, "Spouse" means a Participant's legal spouse if recognized by state and federal law.

2.36 "Statutory Leave" means an unpaid leave of absence under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act.

2.37 "Vision Care Expense" means an expense for vision care: (i) which constitutes "medical care" as that term is used for purposes of Section 105(b) of the Code (including non-prescription or "over-the-counter" expenses not allowable as a deduction under Section 213 of the Code, except as prohibited by Code Section 106(f)); (ii) coverage for which is "permitted coverage" within the meaning of Section 223 of the Code, and regulations and guidance issued thereunder; and (iii) is incurred by a Participant for himself or a person who, at the time the expense is incurred, is his Spouse or Dependent.

2.38 "Vision Coverage" means group vision coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which: (i) satisfies the requirements of Sections 105 and 106 of the Code; and (ii) is "permitted coverage" within the meaning of Section 223 of the Code, and regulations and guidance issued thereunder.

SECTION 3
PARTICIPATION

3.1 Eligibility Requirements. An Employee shall be eligible to participate in the Plan if he has High Deductible Health Coverage and satisfies the following requirements:

- is a regular Full-Time employee of the Employer or a regular Part-Time Employee of the Employer;
- who is in an eligible employment status as provided in the Summary Plan Description and/or Health Care Program Decision Guide or successor document; and
- who has elected High Deductible Health Coverage and is making contributions to a Code Section 223 Health Savings Account.

3.2 Participation Date. An eligible Employee shall generally become a Participant in the Plan on the first day of employment, provided he still satisfies the eligibility requirements of Section 3.1 on that date, and has completed and filed all of the forms required for participation by the Plan Administrator. The participation date

with respect to each Coverage type may be further restricted by each Program, as follows:

- Dental and High Deductible Health Coverage: for new hires, participation begins the first day of the month following the hire date, or on the hire date if that occurs on the first of the month. For Employees becoming eligible for benefits under the plan due to a change in status (e.g., those changing from an ineligible to an eligible status, or those being hired by the University who have worked for an Affiliate within the last 30 days), coverage will be effective the first of the month following the date of the appointment (or on the date of the appointment if that occurs on the first of a month), or the first day of the pay period following the date the enrollment form is signed (if submitted before any applicable administrative processing deadline), whichever is later.

- Health Care Expense Account and Dependent Care Expense Account: participation begins the date the enrollment form is completed, or the date of the appointment or change to eligible status, whichever is later.

- Health Savings Account: participation begins the first day of the pay period following the date the account is established, the first day of the pay period following the date the enrollment form is signed (if submitted before any applicable administrative processing deadline), or the date of the appointment or change to eligible status, whichever is later.

In the event of a conflict between the participation date listed above and that in the governing plan document for the specific program, the governing document for that program shall be controlling.

However, no Employee shall be eligible to participate in the Plan until the Effective Date or, in the case of an Employee of an Affiliated Employer, the effective date that Affiliated Employer adopts the Plan, as indicated in Section 2.16.

3.3 Duration of Participation. Except as otherwise provided in this Plan, an Employee shall continue as a Participant so long as he remains an Employee, satisfies the eligibility requirements of this Section 3, makes any required Contributions, and continues to complete and file the forms required for participation by the Plan Administrator.

3.4 Reinstatement of Former Participant. Subject to Sections 4.10(B), 5.3(G) and 5.3(H), a Participant whose employment with the Employer terminates and then

resumes shall become a Participant again if and when he again meets the requirements of this Section 3.

SECTION 4
CONTRIBUTIONS AND BENEFITS

4.1 Participant Elections. A Participant may elect to receive his compensation from the Employer in cash, or have a portion thereof credited to his Account(s).

4.2 Maximum Contributions. The Employer or Plan Administrator shall provide advance written notice to each Participant of the minimum and maximum amount of Contributions he can make for a Plan Year (and for each Account), and if the maximum Contribution limit is pro rated for an Employee who is not a Participant during an entire Plan Year (i.e., multiplied by a fraction, the numerator of which is the number of full months of the Plan Year during which he is a Participant, and the denominator of which is the number of full months during the entire Plan Year.) Such maximum contributions shall be communicated in the Summary Plan Description and/or Health Care Program Decision Guide or successor document. If a Participant contributes to a Dependent Care Expense Account pursuant to this Plan in addition to a Dependent Care Expense Account pursuant to the plan of an Affiliate, then the Participant's contributions to both such accounts shall be aggregated for purposes of determining whether the Participant has met or exceeded the maximum Contribution amount.

4.3 Credits to Accounts. Contributions shall be credited, through equal payroll deductions, to the Account designated for such Contributions. Subject to the provisions in Section 5 regarding permissible changes to Contribution Elections, the amount credited to an Account for each payroll period shall be the total amount of such Contributions divided by: (i) the number of pay periods in the Plan Year; or (ii) for an Employee who becomes a Participant during the Plan Year, the number of the Participant's pay periods remaining in the Plan Year after he becomes a Participant. Notwithstanding the preceding sentence, except as provided in Section 4.10(B), Contributions shall cease when an Employee ceases to satisfy the eligibility and participation requirements for the Plan.

4.4 Dependent Care and Eligible Health Care Expenses. No Participant shall be entitled to payment or reimbursement for Dependent Care Expenses or Eligible Health Care Expenses incurred in any Plan Year unless the expense is incurred on or after the date he became a Participant. Payment or reimbursement for Dependent Care Expenses and Eligible Health Care Expenses shall be made at least monthly, provided the Participant files a claim for payment or reimbursement prior to any scheduled cutoff imposed by the Claims Administrator before a scheduled payment/reimbursement date. No Participant shall be entitled to

payment or reimbursement for Eligible Health Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein. No Participant shall be entitled to payment or reimbursement for Dependent Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein.

The Plan Administrator shall inform Participants of the claims process and also provide them with forms to request payment or reimbursement for Dependent Care Expenses and Eligible Health Care Expenses. Such requests shall be accompanied by a copy of the Explanation of Benefits or bill and/or other documentation and information substantiating the expense, and shall contain the Participant's signed statement that the Dependent Care Expense or Eligible Health Care Expense has not been reimbursed, and is not reimbursable, from any other source. For Post-Deductible Expenses that are not Dental or Vision Care Expenses, the information shall also include information from an independent third-party that the Participant has satisfied his Minimum Annual Deductible Amount. The amount credited to a Participant's Dependent Care Expense and Health Care Expense Accounts shall be reduced by the amount paid from such Accounts.

Notwithstanding the above, the Plan Administrator may make arrangements for automatic payment or reimbursement for certain Dependent Care Expenses and Eligible Health Care Expenses.

Payment of other Qualified Benefits shall be made automatically.

4.5 Maximum Benefits. The amount available to a Participant for a particular Qualified Benefit shall equal the amount then credited to the Account for that Qualified Benefit Account; provided, however, the amount available for payment or reimbursement for Eligible Health Care Expenses incurred during a Plan Year shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Eligible Health Care Expenses incurred during the Plan Year.

4.6 Cessation of Contributions. If Contributions to a Participant's Health Care Expense Account cease during a Plan Year, he may submit claims only for payment or reimbursement of Eligible Health Care Expenses incurred before his Contributions cease. All such claims must be submitted within 90 days after the date his Contributions cease. If Contributions to a Participant's Dependent Care Expense Account cease during a Plan Year, he may submit claims only for payment or reimbursement of Dependent Care Expenses incurred for services provided through the end of the Plan Year during which he was a Participant. The

amount available for reimbursement for Dependent Care Expenses shall be limited to the amount credited to his Dependent Care Expense Account. If Contributions to a Participant's Health Savings Account cease during a Plan Year, the Participant can continue to make contributions to and claim benefits from a Health Savings Account, outside of this Plan, subject to the HSA governing documents and procedures determined by the HSA trustee/custodian.

4.7 Forfeitability of Benefits. Except as provided in Section 4.8 below, if total Contributions to a Participant's Account exceed the Qualified Benefits paid from that Account for the Plan Year, the Participant shall forfeit the excess Contributions.

4.8 No Grace Period. The Plan does not provide for the grace period provisions permitted in accordance with IRS Notice 2005-42.

4.9 Continuation During Leaves of Absence. The Plan Administrator or Employer will advise any Employee who is eligible for a Statutory Leave of his right to maintain Coverage during the Statutory Leave, and his specific rights and obligations if he chooses to continue such Coverage during the Statutory Leave. The Plan Administrator or Employer shall advise each Employee who takes any other type of leave of absence of his right, if any, to maintain such Coverage in effect during the period of leave, and the Employer's right, if any, to recover the amount of Contributions paid by the Employer on behalf of the Employee during the leave period. Such provisions shall be contained in the Summary Plan Description and/or the University of Rochester Health Care Program Decision Guide or successor document.

4.10 Termination of Employment. If a person ceases to be a Participant during a Plan Year, he shall be eligible to receive Qualified Benefits incurred on or prior to the date he ceases participation; provided, however, that claims for Dependent Care Expenses and Eligible Health Care Expenses are subject to the following rules. These rules shall also apply if a Participant ceases to be an eligible Participant due to termination of employment with the Employer, even if the Participant remains or becomes employed by an Affiliate, if that Affiliate is not an Affiliated Employer participating in this Plan.

A) If a Participant's employment terminates during the Plan Year, he may submit claims only for payment or reimbursement of Dependent Care Expenses incurred for services provided through the end of the Plan Year during which he was a Participant. The amount available for reimbursement for Dependent Care Expenses shall be limited to the amount credited to his Dependent Care Expense Account. All such claims must be filed no later than the April 30th following the end of the Plan Year.

B) If a Participant's employment terminates during the Plan Year and he is entitled to continue Contributions to his Health Care Expense Account through the end of that Plan Year pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), he may make after-tax contributions to such Account for that period. If the Participant makes such election, he may submit claims for payment or reimbursement of Eligible Health Care Expenses incurred: (i) through the end of the Plan Year in which his employment terminated; or (ii) if earlier, the date his after-tax contributions cease. The amount available for payment or reimbursement of such Eligible Health Care Expenses shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Eligible Health Care Expenses incurred during the Plan Year. If the Participant does not make such election, or makes such election but ceases after-tax contributions prior to the end of the Plan Year: (i) he may submit claims only for payment or reimbursement of Eligible Health Care Expenses incurred prior to his termination or the date his after-tax contributions ceased; (ii) all such claims must be submitted within 90 days following the date his employment terminated or the date his after-tax contributions ceased; and (iii) he shall forfeit any amount remaining in his Health Care Expense Account after payment of claims filed before or within such 90 day period.

4.11 COBRA Health Continuation Coverage. The Employer or its designee shall advise each Participant, his Spouse and Dependents of any rights he may have to continued health insurance coverage to continue Contributions to his Health Care Expense Account pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

4.12 Specific Benefits. The specific benefits to which a Participant, his Dependent or beneficiary may be entitled under his Dental and/or Employer Sponsored High Deductible Health Coverage shall be as determined under the applicable plan, program, insurance policy or contract providing such Coverage. The Employer does not guarantee payment of any benefits that may be payable under an insurance policy or contract, and eligibility under this Plan does not guarantee that Participants will satisfy any insurer's requirements for such Coverage.

4.13 Changes in Premiums. The Employer or Plan Administrator shall provide advance written notice to each Participant of the Premiums in effect at the beginning of each Plan Year, and any changes in Premiums during the Plan Year.

4.14 Statement of Benefits. By January 31 of each year, the Employer shall provide, in the form provided under the Code, a statement to all Participants showing the

Participant's Contributions to his Dependent Care and Health Care Expense Accounts for the previous calendar year.

4.15 Experience Gains. Any amounts forfeited by Participants from Health Care Expense Accounts or Dependent Care Expense Accounts in accordance with Section 4.7 hereof, may be:

A) In the case of forfeitures from Dependent Care Expense Accounts only, retained by the Employer;

B) If not retained by the Employer, or in the case of Health Care Expense Accounts, may be used only in one or more of the following ways:

1) to reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis, as described in Prop. Treas. Reg. § 1.125-5(o)(2) (or successor regulations);

2) returned to employees on a reasonable and uniform basis, as described in Prop. Treas. Reg. § 1.125-5(o)(2) (or successor regulations);

3) to defray expenses to administer the plan; or

4) any other purpose permitted by Prop. Treas. Reg. § 1.125-5(o) (or successor regulations).

SECTION 5
ELECTION PROCEDURES

5.1 Annual Elections. Before the beginning of each Plan Year, the Plan Administrator shall provide one or more election forms (written or in electronic form) to each Employee eligible to participate in the Plan that Plan Year. Employees who become eligible to participate in the Plan during the Plan Year shall be provided with election form(s) during the month in which they meet the eligibility requirements. The completed form(s) shall indicate the Contributions to be credited to the Account for each Qualified Benefit. Election form(s) for a Plan Year must be completed and filed with the Employer on or before the date specified by the Plan Administrator. A Participant's failure to submit election form(s) by the specified date shall be deemed an election to not make any Contributions for the Plan Year.

Notwithstanding the above, at the times described above, the Employer may instead notify each Employee who is eligible to participate in the Plan that his Premium for Dental and/or High Deductible Health Coverage shall automatically

be paid through Contributions to the Plan, unless the Employee elects otherwise in writing signed by the Employee and filed with the Plan Administrator. An Employee's failure to make such an election shall be deemed an election to participate in and make such Contributions to the Plan.

5.2 Irrevocability of Elections. Once a Participant makes his Contribution Elections for a Plan Year and the Plan Year commences, the Contribution Elections shall be irrevocable for the entire Plan Year, except as provided in Section 5.3.

5.3 Changes in Status. Participants may prospectively revoke their Contribution Elections and make new Contribution Elections for a Plan Year in accordance with the provisions of this Section. This Section shall be interpreted in a manner consistent with Section 125 of the Code and other guidance issued thereunder.

A) Health Plan Special Enrollment Rights. Contribution Elections for Dental and High Deductible Health Coverage may be changed in a manner consistent with the exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996, as amended.

B) COBRA Coverage. If a Participant, his Spouse or Dependent child becomes eligible for continuation coverage under the Consolidated Omnibus Reconciliation Act of 1985 as amended (or similar state law) under a group health plan of the Employer, the Participant may increase his Contribution Elections for Dental or High Deductible Health Premiums to pay for the continuation coverage.

C) Court Judgment, Decree or Order. A Participant's Contribution Election for Dental or High Deductible Health Coverage may be increased to pay for a Dependent child's or foster child's Dental or High Deductible Health Coverage as required under a court order or state agency notice resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined under Section 609 of ERISA). Similarly, Contribution Elections may be reduced to reflect any decrease in Dental or High Deductible Health Coverage Premiums if such judgment, decree or order requires someone else to provide such Coverage for such child. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Election for his Health Care Expense Account may also be increased or reduced in a manner consistent with such court judgment, decree or order.

D) Entitlement to Medicaid. A Contribution Election for High Deductible Health Coverage Premiums may be reduced if the Participant, his Spouse or Dependent becomes entitled to Medicaid coverage (other than only the program for distribution of pediatric vaccines). A Participant's

Contribution Election for High Deductible Health Premiums may be increased if the Participant, his Spouse or Dependent loses such Medicaid eligibility. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Elections for his Dental and Vision Premiums and a Participant's Contribution Election for his Health Care Expense Account may also be reduced or increased when the Participant, his Spouse or Dependent becomes entitled to, or loses, such Medicaid eligibility.

E) Loss of Qualifying Individual Status. A Participant's Contribution Election for his Dependent Care Expense Account may be changed in a manner consistent with a change in the status of an individual as a Qualifying Individual.

F) Other Changes in Status. Contribution Elections may change on account of and in a manner consistent with a change in: (i) the Participant's legal marital status (including: marriage, divorce, death of a Spouse, legal separation, or annulment); (ii) the number of the Participant's Dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child); (iii) the employment status of the Participant, his Spouse or Dependent resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes the Participant, his Spouse or Dependent to become eligible, or cease to be eligible, for Coverage under this Plan or other employer plan providing Qualified Benefits; (iv) a Dependent's eligibility for Dental or Employer Sponsored High Deductible Health Coverage due to age, student status, marriage or similar circumstance; (v) any other change considered to be a change in status under Section 125 of the Code and regulations thereunder that is listed in the Summary Plan Description and/or Health Care Program Decision Guide or successor document.

G) Special Rule for Termination of Employment. Notwithstanding Section 5.3(F), but subject to Section 5.3(H), if a Participant's employment with the Employer terminates and then resumes in the same Plan Year within a period of 30 days or less, his Contribution Elections in effect before termination shall automatically be reinstated upon resumption of employment, unless some other intervening event has occurred that would permit a change to one or more Contribution Elections. If the Participant terminates employment with an Affiliate that does not participate in the Plan, and is hired by the University within 30 days or less, then the hire shall be treated as a change in worksite, and the Participant may enroll consistent with Section 5.3 (F).

H) Special Rules for Statutory Leave. If a Participant takes a Statutory Leave, the Participant may (i) revoke his Contribution Elections at the beginning of the Statutory Leave and make new Contribution Elections at the end of the Statutory Leave; or (ii) keep his Contribution Elections in place and make contributions during the leave as follows:

a) continue to pay the Employee's share of Contributions with after-tax payments during the Statutory Leave, or to the extent the employee continues receiving pay during the leave, with pre-tax contributions taken from such taxable income; or

b) the Employer may elect to pay the Employee's share of Contributions during a Statutory Leave and recover the cost of these payments through pre-tax payroll deductions after the Statutory Leave if the Employer does so for all Participants on the same type of Statutory Leave, except that the Employer will not make the Employee's elective contributions to a Health Care Expense Account, Dependent Care Expense Account, or Health Savings Account.

A Participant shall not be eligible for reimbursement for Health Care Expenses or Dependent Care Expenses incurred during a period in which Contributions cease as a result of a Statutory Leave.

The maximum period that the employee will be allowed to continue participation pursuant to this provision is for the duration of statutory leave under the Family and Medical Leave Act (generally up to 12 weeks, or up to 26 weeks if the leave reason is taken to care for an injured or ill covered servicemember), and for up to 12 months if the leave is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Participants who remain on leave after exhausting such maximum period, may elect COBRA continuation coverage (see Section 4.10) or, in the case of USERRA leave, continuation coverage for up to 24 months from the date the leave began in accordance with the regulations promulgated pursuant USERRA, if those provision are more favorable to the Participant.

I) Change in Premium. If Participants' Premium for Dental and/or Employer Sponsored High Deductible Health Coverage changes during a Plan Year, there shall be an automatic corresponding change to the Participants' Contributions for Dental and/or Employer Sponsored High Deductible Health Premiums.

J) Change in Dependent Care Expense. If there is a change in a Participant's dependent care provider or in the dependent care provider's cost for services, the Participant may make a corresponding change to his Contribution Election for his Dependent Care Expense Account (provided that, in the case of a change in a dependent care provider's cost for services, the dependent care provider is not a qualifying child or qualifying relative of the Participant within the meaning of Sections 152(a) of the Code.

K) Change in Coverage Options. If a Dental and/or Employer Sponsored High Deductible Health Coverage option is added, the Contribution Election for Dental and/or Employer Sponsored High Deductible Health Premiums for a Participant who elects the new Coverage option shall be changed to correspond to the Participant's Premium for that Coverage. If a Dental and/or High Deductible Health Coverage option is eliminated, the Contribution Election for Dental and/or High Deductible Health Premiums for an affected Participant shall be changed to conform to the change in the Participant's Premium for Coverage.

L) Change in Coverage under Other Employer's Plan. A Participant may change his Contribution Elections (other than his Contribution for his Health Care Expense Account) under this Plan in a manner consistent with a change by his Spouse, former Spouse or Dependent under another plan providing Qualified Benefits if the change under such other plan (i) is permitted under the Sections above; or (ii) is made for the normal election period under such other plan and that period is different from the Plan Year of this Plan.

M) Loss of Other Group Health Coverage. A Participant may increase his Contribution Election for Dental or Employer Sponsored High Deductible Health Premiums under this Plan if the Participant, his Spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan, through no fault of his own.

N) Prospective Changes to Health Savings Account Contributions Allowed at any Time. Participants may prospectively change or revoke salary reduction elections for a Health Savings Account contributions at any time, so long as the election is made by any applicable administrative processing deadline imposed by the Employer, Plan Administrator or designee.

5.4 Limits on Contribution Election Changes. Contribution Election changes must be made within 30 days after a change in status event listed in Section 5.3, except that Participants experiencing a HIPAA special enrollment right in connection with losing eligibility for, or becoming eligible for premium assistance under, Medicaid or Child Health Insurance Program, must make election changes within 60 days after the event. Such election changes shall be effective at the time prescribed by the Plan Administrator in the Summary Plan Description. A Participant who changes his Contribution Election for his Health Care Expense Account during a Plan Year may not reduce his elected amount below the amount of Eligible Health Care Expenses submitted for reimbursement during the Plan Year.

5.5 Nondiscrimination Requirements. The Plan Administrator may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable nondiscrimination requirements and all applicable limitations on Qualified Benefits provided to Highly Compensated Participants and Key Employees. These actions include the reduction of Contributions made by Highly Compensated Participants or Key Employees, based on a uniform and consistent method applicable to all Highly Compensated Participants or Key Employees.

For purposes of the applicable Code nondiscrimination requirements, this Plan and the University of Rochester Cafeteria Plan and Flexible Spending Account Plan shall be considered a single plan.

SECTION 6
PLAN ADMINISTRATION

6.1 Plan Administrator. The Associate Vice President of Human Resources shall be the Plan Administrator. The Employer reserves the right to appoint a different Plan Administrator and/or designate one or more other persons, including an insurance company or third party administrator, to carry out some or all of the duties under the Plan.

6.2 Powers. The Plan Administrator has full authority and responsibility to control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan (but not to modify or amend the Plan) and to decide any and all questions arising in the administration, interpretation, and application of the Plan. The Plan Administrator shall establish whatever rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of the Plan Administrator or its action with respect to the Plan shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the Plan.

6.3 Delegation of Responsibilities. The Plan Administrator may delegate any of his duties or responsibilities to other persons. Any such allocation or delegation of responsibilities shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated.

6.4 Agents and Contractors. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may employ, with the approval of the Plan Administrator, one or more accountants, legal counsel or other persons as shall be deemed necessary for the effective control and management of the operation and administration of the Plan. The Plan Administrator, the Employer and its officers and trustees, and any person to whom any duty or responsibility has been delegated by the Plan Administrator shall be entitled to rely upon all tables, certificates, opinions and reports furnished by any duly appointed accountant, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, certificates, opinions or reports.

6.5 Claims Administrator. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may, with the approval of the Plan Administrator, by written instrument appoint an insurance company, third party administrator or other party to act as Claims Administrator, to act as the claims fiduciary to construe the terms of the Plan and trust and determine eligibility for benefits, process claims under the Plan, and to carry out any and all of the Plan Administrator's administrative duties under the Plan to the extent specified in such instrument.

6.6 Expenses. The Plan Administrator shall not receive any compensation from the Plan for his services, but the Employer may pay the Plan Administrator a salary and the Plan may reimburse the Plan Administrator for any necessary expenses incurred.

6.7 Records. The Plan Administrator and his designees shall maintain records showing the fiscal transactions of the Plan.

6.8 Indemnification. To the extent not covered by insurance, the Employer will indemnify the Plan Administrator and any employee of the Employer acting on the Plan Administrator's behalf, against all claims, loss, damages, expenses and liability arising from any action or failure to act under the Program to the fullest extent permitted under the law and the Employer's governing rules.

6.10 Claims Procedures. Qualified Benefits shall be paid in accordance with the terms of the Plan. A Participant who disagrees with a decision concerning his right to

participate in the Plan or wishes to make a claim for a Qualified Benefit may file a claim in writing. The Employer, the Plan Administrator, and/or the Claims Administrator shall establish and maintain claims procedures in accordance with ERISA, which shall include: (i) a procedure for advising claimants on how to make claims for benefits; (ii) a procedure for the review of such claims and giving timely written notice to the claimant concerning the determination made on the claim; and (iii) a procedure for requesting a review of any claim that is denied in whole or part and giving timely written notice to the claimant concerning the decision on review.

Claims regarding eligibility for participation should be submitted in accordance with the procedures outlined in Exhibit B to the University of Rochester Welfare Benefits Wrap Plan Document. All claims for benefits under a Program shall be submitted to the appropriate Claims Administrator in accordance with the terms of that Program and shall be subject to the claims review procedure for that Program.

Any claim for payment or reimbursement for Health Care Expenses or Dependent Care Expenses incurred in a Plan Year must be filed with the applicable Claims Administrator no later than the April 30th following the end of the Plan Year, or in the case of the Health Care Expense Account 90 days after he ceases participation in the Plan if earlier, or any earlier date specified in the Plan. Any other claim related to the Health Care Expense Account or Dependent Care Expense Account must be filed no later than the April 30th following the end of the Plan Year to which the Qualified Benefit relates, or if earlier 90 days after he ceases participation in the Plan in the case of the Health Care Expense Account, or any earlier date specified in the Plan.

6.11 Qualified Reservist Distributions. Notwithstanding any other provision of the Plan, a "Qualified Reservist" (as described below) may request and receive a distribution from his Health Care Expense Account (a "Qualified Reservist Distribution") in accordance with the following provisions.

A) A Qualified Reservist is an Employee who, by reason of being a member of a reserve component, is ordered or called to active duty for a period beginning or continuing after June 18, 2008 and which is either an indefinite period or is for 180 days or more (without regard to whether the actual period of active duty is less than 180 days or is otherwise changed). For purposes of this provision:

1) "reserve component" means the Army National Guard of the United States, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of the United States, the Air Force Reserve, Coast Guard Reserve, or Reserve Corps of the Public Health Service;

2) an initial order or call to active duty and any subsequent order(s) or call(s) to duty extending the initial order or call to active duty shall be aggregated when determining if the 180 day requirement above is satisfied; and

3) the Employer may rely on the order(s) or call(s) to determine the period an Employee has been ordered or called to active duty.

B) To receive a Qualified Reservist Distribution, a Qualified Reservist must first:

1) provide the Employer with a copy of his order(s) or call(s) to active duty; and

2) request the Qualified Reservist Distribution by completing and filing with the Employer a request form (available from the Employer) no earlier than the date of his order or call to active duty and no later than the last day of the Plan Year that includes the date of his order or call to active duty.

C) The maximum amount available for a Qualified Reservist Distribution shall equal: (i) the Employee's total pre-tax salary reduction Contributions made to his Health Care Expense Account for the Plan Year that includes the date of his order or call to active duty (determined as of the date of his Qualified Reservist Distribution request); minus (ii) the amount distributed from his Health Care Expense Account for Eligible Health Care Expenses incurred during that Plan Year (determined as of the date of his Qualified Reservist Distribution request).

D) In no event shall the amount available for a Qualified Reservist Distribution include any amount attributable to Contributions to the Employee's Health Care Expense Account which are for a Plan Year ended on or before January 1, 2009 or for a Plan Year which ended before his order or call to active duty.

E) The Employer shall pay a Qualified Reservist Distribution to the Employee within a reasonable time, but not more than sixty (60) days after the Employee's request for the Qualified Reservist Distribution.

F) An Employee may receive only one Qualified Reservist Distribution during the same Plan Year.

G) Any Employee who receives a Qualified Reservist Distribution may continue to submit claims for Eligible Health Care Expenses incurred

before the date he requests the Qualified Reservist Distribution, and such claims shall be processed and paid in accordance with the terms of the Plan. The amount available to pay such claims shall equal the amount of his Contribution Election for Health Care Expenses for the Plan Year in which he requests the Qualified Reservist Distribution, minus (i) the total amount of Eligible Health Care Expenses paid or reimbursed from his Health Care Expense Account prior to the date he requests the Qualified Reservist Distribution, and (ii) the amount of the Qualified Reservist Distribution.

H) An Employee who receives a Qualified Reservist Distribution may submit claims for Eligible Health Care Expenses incurred after the date he requests the Qualified Reservist Distribution only if he is entitled and elects to continue participation in the Plan by making contributions after such date pursuant to the provisions of Section 5.3H of this Plan, and/or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and/or the Uniformed Services Employment and Reemployment Rights Act (USERRA); provided, however, if his contributions cease prior to the end of a Plan Year: (i) he may submit claims only for payment or reimbursement of Eligible Health Care Expenses incurred between the beginning of that Plan Year and the date his contributions cease; (ii) all such claims must be submitted within 90 days following the date his contributions cease; and (iii) he shall forfeit any amount remaining in his Health Care Expense Account after payment of claims filed before or within such 90 day period. Claims for Eligible Health Care Expenses incurred after the date he requests the Qualified Reservist Distribution shall be processed and paid in accordance with the terms of the Plan. The amount available to pay any claim incurred during the Plan Year in which he requests the Qualified Reservist Distribution shall equal the amount of his Contribution Election for Health Care Expenses for that Plan Year, minus (i) the total amount of Eligible Health Care Expenses incurred during that Plan Year and paid or reimbursed from his Health Care Expense Account prior to the date of the claim, and (ii) the amount of the Qualified Reservist Distribution.

I) Qualified Reservist Distributions shall be uniformly available to all Participants who are Qualified Reservists.

J) Qualified Reservist Distributions shall be included in the gross income of the Employees who receive them and reported by the Employer as wages.

K) This Subsection shall be interpreted and applied in a manner consistent with IRS Notice 2008-82 and Treasury Regulations and other Internal Revenue Service guidance regarding Qualified Reservist Distributions.

6.12 Health Savings Account Contributions. The following provisions apply to a Participant's HSA contributions made through this Plan.

A) Definitions. For the purposes of this Section, the following terms have the following meanings:

1) "HSA Benefits" means Contributions made to a Health Savings Account on pre-tax salary reduction basis under this Plan.

2) "Medical Expenses" means an expense incurred by a Participant for himself, his Spouse or his Dependent for "medical care," as that term is used for purposes of Section 105(b) of the Code, as amended by Section 106(f) of the Code, except that insurance premiums or expenses for long-term care services are not eligible for reimbursement from a Health Care Expense Account

3) "General Health FSA" means a health care flexible spending account offered by the Employer pursuant to Code Sections 125 and 105 for reimbursement of Medical Expenses, or under such an account under any other employer's plan.

4) "Limited Purpose FSA" means a Health Care Expense Account under this Plan or such an account under any other employer's plan (i.e., a limited-purpose or post-deductible flexible spending account under another employer's plan where coverage is limited to only expenses for vision, dental, post-deductible medical and/or preventive medical care, as described in Revenue Ruling 2004-45).

5) "General HRA" means a general Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible Medical Expenses.

6) "Limited Purpose HRA" means a Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible Health Care Expenses, where coverage is limited to only expenses for vision, dental, post-deductible medical and/or preventive medical care, as described in Revenue Ruling 2004-45.

B) Employees may elect HSA Benefits only if the Employee is enrolled in High Deductible Health Coverage, meets criteria for participation outlined in the Summary Plan Description and/or Health Care Program Decision Guide or successor document, and meets other criteria for participation in an HSA outlined in Code § 223.

C) To the extent provided in the enrollment materials, the Employer may contribute to an Employee's HSA under the Plan. The enrollment materials, Summary Plan Description and/or Health Care Program Decision Guide or successor document will specify the amount of the Employer's HSA contribution, if any.

D) Participants may prospectively change or revoke salary reduction elections for HSA Benefits monthly.

E) If an Employee participates in a General Health FSA, then the Employee cannot elect HSA Benefits at any time during the General Health FSA's coverage period, even if the General Health FSA balance is reduced to $0 prior to the end of the coverage period. These restrictions do not apply to a Limited Purpose FSA. Likewise, if an Employee participates in a General HRA, then the Employee cannot elect HSA Benefits at any time during the General HRA's coverage period, even if the General HRA balance is reduced to $0 prior to the end of the coverage period. These restrictions do not apply to a Limited Purpose HRA. In addition, if an Employee is a beneficiary under a General Health FSA or General HRA, such as if the Employee's Spouse participates in a General Health FSA or participates in a General HRA and the employee's Health Care Expenses are eligible for reimbursement from the Spouse's General Health FSA or General HRA, then the Employee cannot elect HSA Benefits at any time during the General Health FSA or General HRA's coverage period, even if the General Health FSA or General HRA balance is reduced to $0 prior to the end of the coverage period.

F) An Employee who was a participant or beneficiary in a General Health FSA cannot elect HSA Benefits for any of the first three calendar months following the close of the General Health FSA's plan year if the General Health FSA provides a grace period under Prop. Treas. Reg. § 1.125-1(e) or successor regulations. However, the employee can elect HSA Benefits immediately following the close of the General Health FSA's plan year despite any grace period if the account balance in the General Health FSA was $0 at the close of the General Health FSA's plan year.

G) An Employee who was a participant or beneficiary in a General HRA may elect HSA Benefits under this Plan following the close of the General HRA plan year if the General HRA balance is $0 at the close of the General HRA's plan year, and the employee or other account holder (as applicable) waives participation in the General HRA for the following HRA plan year prior to the beginning of that plan year (assuming waiver is permitted by the applicable General HRA plan). Alternatively, even if the General HRA

balance is greater than $0 at the end of the General HRA plan year, an Employee may elect HSA Benefits under this Plan following the close of the plan year if the employee or other account holder (as applicable) elects to suspend participation in the General HRA for the following plan year, prior to the beginning of that plan year (assuming suspension is permitted by the applicable HRA plan).

H) The annual contribution to an Employee's HSA cannot exceed the limits described in Code § 223 and applicable Department of Treasury and/or IRS regulations and guidance. In no event shall the amount elected for HSA Benefits under this Plan exceed the statutory maximum amount for HSA contributions corresponding with the Participant's High Deductible Health Coverage option (i.e., single or family) for the calendar year in which the contribution is made ($3,050 for single and $6,150 for family in 2011, $3,100 for single and $6,250 for family in 2012). An additional catch-up contribution ($1,000 in 2011 and 2012) may be made by Participants who are age 55 or older.

In addition, the HSA Benefits maximum annual contribution shall be:

1) reduced by any matching (or other) contribution made by the Employer on the Participant's behalf (other than HSA Benefits) made under the Plan, if any; and

2) prorated for the number of months in which the Participant is an eligible Employee for HSA Benefits purposes.

I) HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis and for the Employer to make contributions to an Employee’s HSA, if any.

J) The HSA is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of “qualified eligible medical expenses” as set forth in Code §223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA in the form of HSA Benefits, and the Employer may elect to contribute to an eligible Employee’s HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The terms and conditions of each participant's HSA trust or custodial account are described in the HSA trust or custodial

agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

Although the HSA trustee/custodian will be chosen by the Employee, not by the Employer, the Employer may limit the HSA providers to whom it will forward contributions that the Employee makes via pre-tax salary reductions under this Plan, but does not endorse of any particular HSA provider. The Service Provider will maintain records to keep track of the HSA Benefits an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

The tax treatment of the HSA (including contributions and distributions) is governed by Code §223.

SECTION 7
AMENDMENT AND TERMINATION OF THE PLAN

7.1 Amendment and Termination. The Employer and the Senior Vice President of Administration and Finance shall have the right to amend this document and the terms of the Plan at any time, including the right to terminate this Plan at any time. The right to amend or modify the Plan includes the right to change the benefits and cost sharing provisions under the Plan. Any amendment shall be in writing and shall be effective only for periods after the later of its adoption date or effective date.

SECTION 8
HIPAA PRIVACY RULES

8.1 Refer to University of Rochester Welfare Wrap Plan. Each "Health Plan", as such term is defined in 45 C.F.R. 160.103 will use and/or disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"), and in accordance with the Privacy Rules outlined in the plan document for the University of Rochester Welfare Wrap Plan, which are hereby incorporated by reference.

SECTION 9
MISCELLANEOUS

9.1 No Employment Rights Conferred. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the

employment of any person. Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate his employment with the Employer at any time.

9.2 No Compensation for Other Purposes. Qualified Benefits paid under the terms of this Plan shall not be treated as additional compensation to the Participant for purposes of determining Contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer unless otherwise provided under the terms of the retirement plan or other benefit program.

9.3 General Assets. Payment of Qualified Benefits shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no trust fund for payment of Qualified Benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609 of ERISA), and except to the extent that this provision may be contrary to other law, Qualified Benefits payable from the Plan shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.

9.4 Impossibility of Performance. In the event that it becomes impossible for the Employer to perform any act under the Plan, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the Plan.

9.5 Gender. For purposes of this Plan, unless the context requires otherwise, whenever the masculine gender is used, it shall also be deemed to include the feminine gender.

9.6 Governing Law. All legal questions pertaining to the Plan shall be determined in accordance with the laws of the State of New York except when those laws are preempted by the laws of the United States.

By signing this instrument, the Employer(s) approves and adopts the terms of the Flexible Spending Account Plan as stated herein.

University of Rochester	N/A
(Employer Name)	(Affiliated Employer Name)
By: [signature]	By:
Print Name: Charles T Murphy	Print Name:
Title: AVP for HR	Title:
Date: 8/16/12	Date:

12549046.16

FIRST AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN

Pursuant to Section 7.1 of the the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (the "Plan"), the University of Rochester amends the Plan as follows effective the date of execution, below:

1. Paragraph (B) of Section 2.9, Dependent, is deleted in entirety and clarified to read:

   B) for purposes of payment or reimbursement of Health Care Expenses from a Participant's Health Care Expense Account, a Participant's Spouse or tax dependent as defined in Code Section 152 (as modified by Code Section 105(b)).

2. A new paragraph is added to section 5.3, Changes in Status, to read as follows:

   N) Special Change in Status Event due to Supreme Court's *Windsor* Decision. If as a result of the Supreme Court's decision in *United States v. Windsor,* a Participant's same-sex spouse or the children of a Participant's same-sex spouse or other individual becomes an eligible Spouse or Dependent under the Plan, then the Participant can elect to add the newly eligible Spouse or Dependents to Medical Coverage and/or Dental Coverage, change Coverage options, pay for Premiums for such benefits on a pre-tax basis, or elect or change Health Care Expense Account or Dependent Care Expense Account contributions. However, the Participant must make these elections or changes within thirty (30) days after the date the Employer communicates in writing to Employees that the *Windsor* decision created a special Change in Status event as a result of the Employee acquiring newly-eligible Dependents. In addition, any election or changes must be consistent with acquiring a newly eligible Spouse or Dependents due to the Supreme Court's decision in *United States v. Windsor*, as determined by the Plan Administrator or his delegate in his sole discretion. However, in the event that subsequent IRS guidance prescribes rules regarding such election changes that are different from the rules described in this paragraph, the Plan Administrator may communicate such rules from IRS guidance to Employees and follow those rules communicated without the need for further amendment to the Plan.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 7th day of August, 2013.

UNIVERSITY OF ROCHESTER

By: [signature]

Title: Associate Vice President for Human Resources

14532275.2

SECOND AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

Pursuant to Section 7.1 of the the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 1, 2014:

1. Section 2.13, Employee, is deleted in its entirety and replaced with:

   2.15 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if any Employer listed in Section 2.14 is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if any Employer listed in Section 2.14 is a limited liability corporation ("LLC"), any member of the LLC; (iv) if an election is made under the Code for any Employer listed in Section 2.14 to be a Subchapter S corporation, any person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer; (v) a Resident or Fellow in an Accredited ACGME Training Program who receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract.

2. Section 2.21, Medical Coverage, is deleted in its entirety and replaced with:

   2.21 "Medical Coverage" means group major medical coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code, and which is not an excepted benefit as described in 29 CFR §2590.732(c), including coverage through a union multiemployer plan to which the Employer contributes on behalf of the Employee.

3. Section 3.1, Eligibility Requirements, is amended by deleting the first bullet in its entirety and replacing it with the following:

   - a regular Full-Time Employee of the Employer or a regular Part-Time Employee of the Employer who is eligible for Medical Coverage;

4. Section 3.2, Participation Date, is amended by deleting the section in its entirety and replacing it with the following:

   3.2 Participation Date. An eligible Employee shall generally become a Participant in the Plan on the first day of the month following or coincident with the hire date, provided he still satisfies the eligibility requirements of Section 3.1 on that date, and has completed and filed all of the forms required for participation by the Plan Administrator. The

participation date with respect to each Qualified Benefit may be further restricted by each program, as follows:

- Medical and Dental Coverage: for new hires, participation begins the first day of the month following or coincident with the hire date. For Employees becoming eligible for benefits under the plan due to a change in status (e.g., those changing from an ineligible to an eligible status, or those being hired by the University who have worked for an Affiliate within the last 30 days), coverage will be effective the first of the month following or coincident with the date of the appointment, or the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), whichever is later.

- Health Care Expense Account and Dependent Care Expense Account: participation begins the first day of the month following or coincident with the date of the hire, appointment, or change to eligible status, or the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), whichever is later.

In the event of a conflict between the participation date listed above and that in the governing plan document for the specific program, the governing document for that program shall be controlling.

However, no Employee shall be eligible to participate in the Plan until the Effective Date or, in the case of an Employee of an Affiliated Employer, the effective date that Affiliated Employer adopts the Plan, as indicated in Section 2.14.

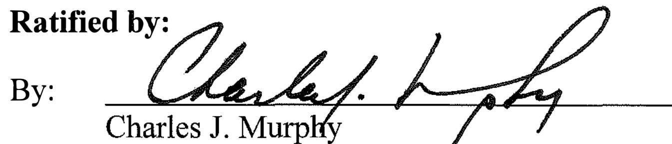
IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 3 day of March, 2014.

UNIVERSITY OF ROCHESTER

By:
Michele R. Hill

Title: Director, University Benefits

Ratified by:

By: 
Charles J. Murphy

Title: Associate Vice President Human Resources

THIRD AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

A. 2104 Amendments

Pursuant to Section 7.1 of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 1, 2014:

1. Section 4.8, No Grace Period, is deleted in its entirety and replaced with:

4.8 Health Care Expense Account Carryovers Permitted. Notwithstanding any other provision of the Plan to the contrary, unused amounts of up to $500 remaining in a Participant's Health Care Expense Account at the end of a Plan Year that begins on or after January 1, 2014 can be used to reimburse the Participant for Health Care Expenses that are incurred during the next Plan Year.

A) Definitions. For the purposes of this Section, the following terms have the following meanings:

1) "General Health FSA" means a Health Care Expense Account under the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) or under the University of Rochester Cafeteria Plan and Flexible Spending Account Plan for Residents & Fellows (With Pre-Tax Insurance Premiums) for reimbursement of Health Care Expenses.

2) "Limited Purpose FSA" means a Health Care Expense Account under the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums) or the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums) for reimbursement of limited-purpose or post-deductible expenses for vision, dental, post-deductible medical and/or preventive medical care, as described in Revenue Ruling 2004-45.

3) "High Deductible Health Coverage" means coverage under a group health plan maintained for Employees by the Employer under a separate plan, program, insurance policy or contract and which: (i) satisfies the requirements of Sections 105 and 106 of the Code; and (ii) qualifies as a high deductible health plan as described in Section 223 of the Code and regulations and guidance issued thereunder.

B) The following conditions shall apply to Health Care Expense Account carryovers:

1) No more than $500 of the Participant's unused Health Care Expense Account amount for a Plan Year may be carried over for use in the next Plan Year.

2) A Participant may elect prior to the beginning of the next Plan Year to waive the carryover for that Plan Year in accordance with procedures established by the Plan Administrator.

3) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit on annual salary reductions under the Health Care Expense Account described in Section 4.2.

4) Health Care Expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year, and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses during the run-out period described in Section 6.10, cannot exceed $500, and will count against the $500 maximum carryover amount.

5) Health Care Expenses incurred in the preceding Plan Year that are submitted during the applicable claims run-out period described in Section 6.10 will be reimbursed first from a Participant's unused amounts credited for the preceding Plan Year that were not carried over to the current Plan Year, and then from amounts carried over from the preceding Plan Year to the current Plan Year. Carryovers from the current Plan Year that are used to reimburse a preceding Plan Year's expense will reduce the amount available to pay the Participant's current Plan Year expenses.

6) If a Participant enrolls in a Health Care Spending Account for the current Plan Year, then funds carried over from the prior Plan Year shall be deposited in the same Health Care Spending Account in which the Participant is enrolled for the current Plan Year (i.e., if the Participant enrolls for a General Health FSA for the current Plan Year, then carryover funds shall be deposited to the General Health FSA account; if the Participant enrolls for a Limited Purpose FSA for the current Plan Year, then carryover funds shall be deposited to the Limited Purpose FSA account).

7) If a Participant is otherwise eligible to participate in a Health Care Expense Account for a Plan Year, but does not elect to make Contributions to such Account for the current Plan Year, then the Participant may still use any carryover funds from the preceding Plan Year for current Plan Year or preceding Plan Year eligible expenses.

    1) If the Participant waives Medical Coverage, then the carryover funds will remain in the same type of Health Care Expense Account (the General Health FSA or the Limited Purpose FSA) in which the Participant was enrolled during the prior Plan Year.

    2) If the Participant elects Medical Coverage, then the carryover funds shall be deposited to the General Health FSA account if the Participant elects Medical Coverage that is not High Deductible Health Coverage, and shall be deposited to the Limited Purpose FSA if the Participant elects Medical Coverage that is High Deductible Health Coverage.

3) Notwithstanding the foregoing, if a Participant does not elect to make Contributions to a Health Care Expense Account for the current Plan Year, and the Participant waives Medical Coverage for the current Plan Year, the Participant shall have the option, prior to commencement of the new Plan Year, to waive a carryover to the General Health FSA or to request that the Participant's carryover funds be deposited to the Limited Purpose FSA, using a form available from the Benefits Office. If the Participant waives the carryover, the Participant may continue to submit claims for expenses incurred during the prior Plan Year until the end of the run-out period (April 30th of the following Plan Year), to be reimbursed from the Participant's available General Health Care FSA amounts in the Health Care Expense Account. Any unused amounts will be forfeited in accordance with the Participant's waiver.

8) The Participant must participate in the Health Care Expense Account as of the last day of the Plan Year to be eligible for the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility, unless a COBRA election is made.

The Plan does not provide for the grace period provisions permitted in accordance with IRS Notice 2005-42.

2. Section 7.1, Amendment and Termination, is amended by deleting the section in its entirety and replacing it with the following:

7.1 Amendment and Termination. The Employer, the Senior Vice President of Administration and Finance, and the Associate Vice President Human Resources shall have the right to amend this document and the terms of the Plan at any time, including the right to terminate this Plan at any time. The Director of University Benefits shall have authority to amend the Plan effective immediately, but subject to subsequent ratification by one of the above named individuals within 90 days thereafter. The right to amend or modify the Plan includes the right to change the benefits and cost sharing provisions under the Plan. Any amendment shall be in writing and shall generally be effective only for periods after the later of its adoption date or effective date, except that where applicable guidance permits an amendment to have retroactive effect, the amendment shall be effective as of the effective date stated in the amendment.

B. 2105 Amendments

The University of Rochester amends the Plan as follows effective January 1, 2015:

1. Section 4.3, Credits to Accounts, is amended by adding a new terminal paragraph as follows:

In addition, the Employer may deposit additional credits to Participants' Accounts, including but not limited to additional contributions to reflect geographic differentials. The amount of and eligibility for such credits, if any, shall be governed by the terms and conditions described in the enrollment materials, the Summary Plan Description and/or the University of Rochester Health Care Program Guide or successor document.

2. Section 5.3, Changes in Status, is amended by adding the following new subparagraph:

   N) Enrollment in Qualified Health Plan Coverage. A Participant may revoke an election for Medical Coverage corresponding with the Participant's intended or completed enrollment in a Qualified Health Plan through a federal or state health insurance Marketplace.

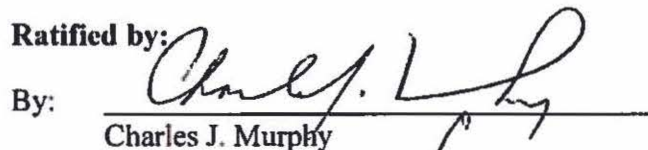
The above amendments are intended to apply to the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Pre-Tax Insurance Premiums), which incorporates by reference the terms of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums).

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 30 day of December, 2014.

UNIVERSITY OF ROCHESTER

By: Michele R. Hill

Title: Director, University Benefits



Ratified by:

By: Charles J. Murphy

Title: Associate Vice President Human Resources

FOURTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

Pursuant to Section 7.1 of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 15, 2015:

1. Section 5.1, Annual Elections, is amended by adding a new terminal paragraph as follows:

   If the Employer does not require an Eligible Employee to make a new election at open enrollment, an Eligible Employee who fails to make a new election during open enrollment will be deemed to have made the same election for payment of Coverage Premiums (but not for Health Care Expense Account Contributions, Dependent Care Expense Account Contributions, or HSA Benefits) as was in effect for the Plan Year just prior to the end of the preceding Plan Year.

2. Section 5.3, Changes in Status, is amended by deleting the current subparagraph I in its entirety and replacing it wih the following:

   I) Change in Premium. If a Participants' Premium for Medical or Dental Coverage changes during a Plan Year, there shall be an automatic corresponding change to the Participants' Contributions for Medical or Dental Coverage Premiums; provided, however, if there is a significant cost change in the Premium for a Medical or Dental Coverage option, an affected Participant may be permitted to make a new election as follows:

      1) If there is a significant increase in the Premium for a Medical or Dental Coverage option, an affected Participant may revoke the election of that Medical or Dental Coverage option and may elect another Medical or Dental Coverage option of the same category (if available) offered by the Employer (or elect medical or dental coverage under another employer's plan), with a corresponding change to his Contribution Election. If no other Employer Medical or Dental Coverage option of the same category is offered by the Employer and available to the Participant, then the Participant may revoke his Medical or Dental Coverage election; the Participant may not revoke his election if another Medical or Dental Coverage option of the same category is offered by the Employer and available to the Participant.

      2) If there is a significant decrease in the Premium for a Medical or Dental Coverage option, an affected Participant may enroll for Medical or Dental Coverage, or may elect Medical or Dental Coverage with the decreased cost and revoke his prior Medical or Dental Coverage election.

The above amendments are intended to apply to the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Pre-Tax Insurance Premiums), which incorporates by reference the terms of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums).

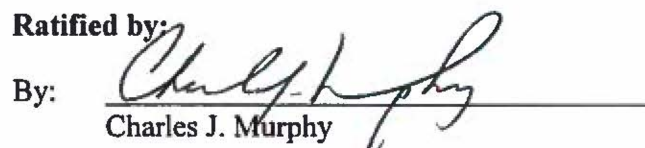
IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 14 day of January 2015.

UNIVERSITY OF ROCHESTER

By:
Michele R. Hill

Title: Director, University Benefits

Ratified by:

By: 
Charles J. Murphy

Title: Associate Vice President Human Resources

FIFTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

Pursuant to Section 7.1 of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 1, 2016:

1. Section 2.13, Employee, is deleted in its entirety and replaced with:

    2.15 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if any Employer listed in Section 2.14 is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if any Employer listed in Section 2.14 is a limited liability corporation ("LLC"), any member of the LLC; (iv) if an election is made under the Code for any Employer listed in Section 2.14 to be a Subchapter S corporation, any person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer; (v) a Resident or Fellow in an Accredited ACGME Training Program who receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract; (vi) a Post-Doctoral Appointee as defined in the Employer's Postdoctoral Appointment Policy, or (vii) an employee classified by the Employer in Time As Reported status.

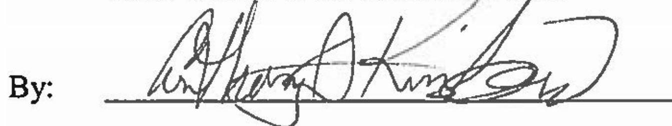
2. Section 7.1, Amendment and Termination, is amended by deleting the section in its entirety and replacing it with the following:

    7.1 Amendment and Termination. The Employer, the Senior Vice President of Administration and Finance, the Associate Vice President of Human Resources, and the Director, University Benefits shall have and retain the right to amend this document and the terms of the Plan at any time, including the right to terminate this Plan at any time. An official publication to employees issued by the University of Rochester Benefits Office, including but not limited to open enrollment materials or the University of Rochester Health Program Guide, which constitutes a Summary of Material Modifications, shall be deemed to be an amendment to the Plan made by the Senior Vice President of Administration and Finance, the Associate Vice President of Human Resources, and/or the Director, University Benefits. The right to amend or modify the Plan includes the right to change the benefits and cost sharing provisions under the Plan. Any amendment shall be in writing and shall generally be effective only for periods after the later of its adoption date or effective date, except that where applicable guidance permits an amendment to have retroactive effect, the amendment shall be effective as of the effective date stated in the amendment.

The above amendments are intended to apply to the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Pre-Tax Insurance Premiums), which incorporates by reference the tenns of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums).

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 14 day of March, 2016.

UNIVERSITY OF ROCHESTER

By: 

Title: Associate VP, Human Resources & Chief HR Officer

FIFTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums)

Pursuant to Section 7.1 of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 1, 2016:

1. Section 2.15, Employee, is deleted in its entirety and replaced with:

    2.15 "Employee" means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if any Employer listed in Section 2.16 is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if any Employer listed in Section 2.16 is a limited liability corporation ("LLC"), any member of the LLC; (iv) if an election is made under the Code for any Employer listed in Section 2.16 to be a Subchapter S corporation, any person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer; (v) a Resident or Fellow in an Accredited ACGME Training Program who receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract; (vi) a Post-Doctoral Appointee as defined in the Employer's Postdoctoral Appointment Policy or (vii) an employee classified by the Employer in Time As Reported status.

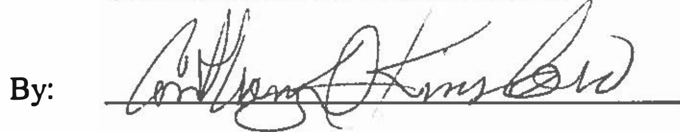
2. Section 7.1, Amendment and Termination, is amended by deleting the section in its entirety and replacing it with the following:

    7.1 Amendment and Termination. The Employer, the Senior Vice President of Administration and Finance, the Associate Vice President of Human Resources, and the Director, University Benefits shall have and retain the right to amend this document and the terms of the Plan at any time, including the right to terminate this Plan at any time. An official publication to employees issued by the University of Rochester Benefits Office, including but not limited to open enrollment materials or the University of Rochester Health Program Guide, which constitutes a Summary of Material Modifications, shall be deemed to be an amendment to the Plan made by the Senior Vice President of Administration and Finance, the Associate Vice President of Human Resources, and/or the Director, University Benefits. The right to amend or modify the Plan includes the right to change the benefits and cost sharing provisions under the Plan. Any amendment shall be in writing and shall generally be effective only for periods after the later of its adoption date or effective date, except that where applicable guidance permits an amendment to have retroactive effect, the amendment shall be effective as of the effective date stated in the amendment.

The above amendment to Section 7.1 is intended to apply to the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums), which incorporates by reference the terms of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums), except to the extent specifically provided otherwise in that plan document.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 14 day of March, 2016.

UNIVERSITY OF ROCHESTER

By: 

Title: Associate VP, Human Resources & Chief HR Officer

4813-2204-9582.1

SIXTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Insurance Premiums)

Pursuant to Section 7.1 of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Premiums) (the "Plan"), the University of Rochester amends the Plan as follows effective January 1, 2020:

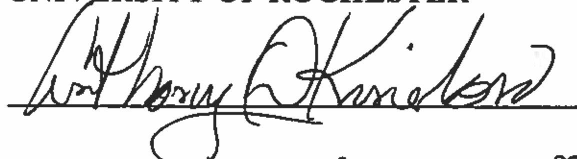
1. A new paragraph (9) is added to Section 4.8 Health Care Expense Account Carryovers Permitted, Subsection (B) (conditions applicable to Health Care Expense Account carryovers), to read as follows:

    9) Before the beginning of each Plan Year, the Participant must elect to participate in the Health Care Expense Account for that Plan Year in order to be eligible to carryover unused Health Care Expense Account funds from the current or a prior Plan Year. Such election generally must take place during open enrollment (Participants on a leave of absence during open enrollment shall be permitted to make Health Care Expense Account elections upon their return from leave).

The above amendment is intended to apply to the University of Rochester Cafeteria Plan and Flexible Spending Account for Residents & Fellows (With Pre-Tax Insurance Premiums), which incorporates by reference the terms of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums), except to the extent specifically provided otherwise in that plan document.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 17th day of February 2020.

UNIVERSITY OF ROCHESTER

By: 

Title: Chief Human Resources Officer

SEVENTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

Pursuant to Section 7.1, effective January 1, 2020, of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows:

1. Section 9 of the Plan is amended to adopt the following new subsections to the end of such Section, as follows:

9.7 *Special Relief Provisions Employer Elected under the Consolidated Appropriations Act, 2021.* Pursuant to the Consolidated Appropriations Act, 2021 (the "CAA"), the Employer elects the following temporary rules that shall supersede any Plan provision to the contrary:

- For Participants who elect during open enrollment to make contributions to a Health Care Expense Account for the 2021 Plan Year, Participants may carry over any unused benefits or contributions remaining in the Participant's Health Care Expense Account from the 2020 Plan Year to the 2021 Plan Year.

- Participants may carry over any unused benefits or contributions remaining in the Participant's Dependent Care Expense Account from the 2020 Plan Year to the 2021 Plan Year.

- For Participants who elect during open enrollment to make contributions to a Health Care Expense Account for the 2022 Plan Year, Participants may carry over any unused benefits or contributions remaining in the Participant's Health Care Expense Account from the 2021 Plan Year to the 2022 Plan Year.

- Participants may carry over any unused benefits or contributions remaining in the Participant's Dependent Care Expense Account from the 2021 Plan Year to the 2022 Plan Year.

- For purposes of determining eligible reimbursements from a Participant's Dependent Care Expense Account, in the case of a Participant who qualifies as an "Eligible Employee" (as defined below), a Dependent Care Expense shall be determined by substituting "age 14" for "age 13" in Code Section 21(b)(1)(B) for the "First Plan Year" (as defined below) and, for a "Participant with Unused DCAP" (as defined below), the Second Plan Year.

  A "Participant with Unused DCAP" may only take advantage of this rule in the Second Plan Year to the extent of amounts paid for dependent care assistance for a dependent who attains age 13 in the First Plan Year or the Second Plan Year and only to the extent of the Participant's unused Dependent Care Expense Account balance for the First Plan Year.

  - "Eligible Employee" means a Participant who (i) is enrolled in a Dependent Care Expense Account for the "First Plan Year" (as defined below); and (ii) has one or more dependents (as defined in Code Section 152(a)(1)) who attain the age of 13

during the First Plan Year; or, in the case of a "Participant with Unused DCAP" (as defined below), the subsequent Plan Year.

- The "First Plan Year" means the 2020 Plan Year.
- The "Second Plan Year" means the 2021 Plan Year.
- "Participant with Unused DCAP" means a Participant who has an unused Dependent Care Expense Account balance for the First Plan Year.

The above provisions are qualified by, and subject to, the requirements of the CAA.

9.8 _Special Claims Rules Adopted in Connection with COVID-19._ The Internal Revenue Service and Employee Benefits Security Administration issued a joint rule in May 2020 extending the timeframes under ERISA and the Internal Revenue Code for making certain benefits-related elections, as further amended and clarified by EBSA Disaster Relief Notice 2021-01 and other guidance (collectively, the "Joint Notice"). To the extent required by the Joint Rule, certain periods beginning from March 1, 2020 until 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (subject to a 12-month maximum period), will be disregarded in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Code section 9801(f);
- The 60-day election period for COBRA continuation coverage under ERISA section 605 and Code section 4980B(f)(5);
- The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C);
- The date for Participants to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Code section 4980B(f)(6)(C);
- The date within which Participants may file a benefit claim under the Plan's claims procedures; and
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure.

The above rules only apply to the portions of the Plan that are subject to ERISA (e.g., the special rules do not apply to Dependent Care Expense Accounts) and to the extent required by applicable law.

9.9 _CARES Act Changes_. Notwithstanding other provisions in the Plan to the contrary, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Expense reimbursable under the Plan's Health Care Expense Account if the expenses for these items are incurred after December 31, 2019. In addition, expenses for menstrual care products incurred by a Participant or his or her Spouse or Dependents after December 31, 2019, shall qualify as Medical Expenses reimbursable under the Plan's Health

Care Expense Account.

9.10 *Contribution/Carryover Limits/Other Changes*. Subject to such additional limits that the Employer may impose, contributions and carryovers are subject to all applicable statutory limits. For the 2019 Plan Year, the Employer extended the run-out period for submitting claims from April 29, 2020, to May 31, 2020.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 30 day of December, 2021.

UNIVERSITY OF ROCHESTER

By: Michelle T. Barrett

Title: Director, University Benefits

SEVENTH AMENDMENT

THE UNIVERSITY OF ROCHESTER CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT PLAN (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Insurance Premiums)

Pursuant to Section 7.1, effective January 1, 2020, of the University of Rochester Cafeteria Plan and Flexible Spending Account Plan (With Limited Purpose/Post Deductible Health FSA and Pre-Tax Insurance Premiums) (the "Plan"), the University of Rochester amends the Plan as follows:

1. Section 9 of the Plan is amended to adopt the following new subsections to the end of such Section, as follows:

9.7 *Special Relief Provisions Employer Elected under the Consolidated Appropriations Act, 2021.* Pursuant to the Consolidated Appropriations Act, 2021 (the "CAA"), the Employer elects the following temporary rules that shall supersede any Plan provision to the contrary:

- For Participants who elect during open enrollment to make contributions to a Health Care Expense Account for the 2021 Plan Year, Participants may carry over any unused benefits or contributions remaining in the Participant's Health Care Expense Account from the 2020 Plan Year to the 2021 Plan Year.

- Participants may carry over any unused benefits or contributions remaining in the Participant's Dependent Care Expense Account from the 2020 Plan Year to the 2021 Plan Year.

- For Participants who elect during open enrollment to make contributions to a Health Care Expense Account for the 2022 Plan Year, Participants may carry over any unused benefits or contributions remaining in the Participant's Health Care Expense Account from the 2021 Plan Year to the 2022 Plan Year.

- Participants may carry over any unused benefits or contributions remaining in the Participant's Dependent Care Expense Account from the 2021 Plan Year to the 2022 Plan Year.

- For purposes of determining eligible reimbursements from a Participant's Dependent Care Expense Account, in the case of a Participant who qualifies as an "Eligible Employee" (as defined below), a Dependent Care Expense shall be determined by substituting "age 14" for "age 13" in Code Section 21(b)(1)(B) for the "First Plan Year" (as defined below) and, for a "Participant with Unused DCAP" (as defined below), the Second Plan Year.

  A "Participant with Unused DCAP" may only take advantage of this rule in the Second Plan Year to the extent of amounts paid for dependent care assistance for a dependent who attains age 13 in the First Plan Year or the Second Plan Year and only to the extent of the Participant's unused Dependent Care Expense Account balance for the First Plan Year.

  - "Eligible Employee" means a Participant who (i) is enrolled in a Dependent Care Expense Account for the "First Plan Year" (as defined below); and (ii) has one or

more dependents (as defined in Code Section 152(a)(1)) who attain the age of 13 during the First Plan Year; or, in the case of a "Participant with Unused DCAP" (as defined below), the subsequent Plan Year.

- The "First Plan Year" means the 2020 Plan Year.
- The "Second Plan Year" means the 2021 Plan Year.
- "Participant with Unused DCAP" means a Participant who has an unused Dependent Care Expense Account balance for the First Plan Year.

The above provisions are qualified by, and subject to, the requirements of the CAA.

9.8 *Special Claims Rules Adopted in Connection with COVID-19.* The Internal Revenue Service and Employee Benefits Security Administration issued a joint rule in May 2020 extending the timeframes under ERISA and the Internal Revenue Code for making certain benefits-related elections, as further amended and clarified by EBSA Disaster Relief Notice 2021-01 and other guidance (collectively, the "Joint Notice"). To the extent required by the Joint Rule, certain periods beginning from March 1, 2020 until 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (subject to a 12-month maximum period), will be disregarded in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Code section 9801(f);
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- The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C);
- The date for Participants to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Code section 4980B(f)(6)(C);
- The date within which Participants may file a benefit claim under the Plan's claims procedures; and
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure.

The above rules only apply to the portions of the Plan that are subject to ERISA (e.g., the special rules do not apply to Dependent Care Expense Accounts) and to the extent required by applicable law.

9.9 *CARES Act Changes*. Notwithstanding other provisions in the Plan to the contrary, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Expense reimbursable under the Plan's Health Care Expense Account if the expenses for these items are incurred after December 31, 2019. In addition, expenses for menstrual care products incurred by a Participant or his or her Spouse or Dependents after

December 31, 2019, shall qualify as Medical Expenses reimbursable under the Plan's Health Care Expense Account.

9.10 *Contribution/Carryover Limits/Other Changes*. Subject to such additional limits that the Employer may impose, contributions and carryovers are subject to all applicable statutory limits. For the 2019 Plan Year, the Employer extended the run-out period for submitting claims from April 29, 2020, to May 31, 2020.

IN WITNESS WHEREOF, the University of Rochester has caused its duly authorized officer to execute this Plan amendment on its behalf on this 30 day of December, 2021.

UNIVERSITY OF ROCHESTER

By: Michelle T. Barrett

Title: Director, University Benefits

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