PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

FLEXIBLE BENEFITS PLAN

Effective Date: January 1, 2002, as amended November 21, 2003, January 1, 2006, January 1, 2010, January 1, 2011, January 1, 2013 and January 1, 2014

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Article 1. Establishment of the Plan

1.1 Establishment of the Plan

The Pennsylvania State System of Higher Education (the "System") hereby establishes a flexible benefits plan for its Employees. This plan is known as the State System of Higher Education Flexible Benefits Plan (the "Plan") and is effective as of January 1, 2002. The Plan is designed to provide eligible Employees with the opportunity to contribute to an account to reimburse themselves on a pre-tax basis for medical expenses and dependent care expenses, and to pay on a pre-tax basis for their share of certain health insurance premiums, and any other qualified benefits as may be added by the System in the future, as provided by the Internal Revenue Code ("Code") and Internal Revenue Service ("IRS") regulations. Although described in this single document, the medical expense reimbursement component and the dependent care expense reimbursement component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code sections 105 and 129.

1.2 Legal Status

Under this Plan, Employees have a choice between cash compensation and qualified non-taxable benefits. Thus, it is the intention of the System that this Plan constitutes a "Cafeteria Plan" under Code section 125, as amended, and regulations thereunder, and that this document fulfill the Section 125 requirement that such plan be reduced to writing. It is the intention of the System that the medical expense reimbursement component of the Plan qualify as a "self-insured medical reimbursement plan" under Code section 105(h) and that the medical care expenses reimbursed under that component are intended to be eligible for exclusion from participating Employees' gross income under Code section 105. In addition, "medical expenses" under the Plan are intended to be those described in Code section 213(d) and regulations thereunder. The dependent care expense component of the Plan and "dependent care expenses" are intended to meet the requirements of Code sections 129 and 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment of the employee and spouse, if any) and regulations thereunder, respectively.

1.3 Not an ERISA Plan

The System is an agency or instrumentality of the Commonwealth of Pennsylvania. Accordingly, although the System has chosen or may choose in the future to have many of the provisions of the Plan be consistent with the requirements of the

Employee Retirement Income Security Act of 1974 (ERISA), the Plan is not subject to Title I and Title IV of ERISA and is exempt from ERISA by virtue of its being a governmental plan, as defined in Section 3(32) of ERISA.

Article 2. Definitions and Construction

2.1 Principal Entities

(a) *System* means the Pennsylvania State System of Higher Education, the sponsor of the Plan, and its successor or successors.
(b) *Plan* means the Pennsylvania State System of Higher Education Flexible Benefits Plan, as amended from time to time.
(c) *Administrator(s)* means the person(s) designated to administer this Plan, as provided by Article 7.
(d) *Claims processor* means the person(s) or administrative services vendor designated by the System to process claims for reimbursement in accordance with the Plan.
(e) *Dependent* or *Dependent Child* means the respective definition of "Dependent" or "Dependent Child" of an Employee as used in each benefit plan that is offered under this Plan. For purposes of the Medical Reimbursement Account and the Dependent Care Reimbursement Account, a Dependent is defined as a Section 152 dependent under the Code. In accordance with current law, including regulations and other guidance issued by the Internal Revenue Service, Dependent shall include a child of the Participant who has not attained age 27.
(f) *Eligible Dependent(s)* means those Dependents or Dependent Children of an eligible Employee who are eligible for benefits under the terms of the underlying benefit plans elected under this Plan.
(g) *Employee* means any permanent, full-time employee of the System (including temporary, full-time faculty with at least an academic year contract) or a permanent, part-time employee (including temporary, part-time faculty with at least an academic year contract) who is scheduled to work every pay period for at least 50 percent of full-time.
(h) *Employer* means the System.
(i) *Participant* means an Employee who has elected to participate in the Plan in accordance with Article 4.
(j) *Spouse* means legally married spouse of the Employee under the state law where the Employee resides and who is treated as a spouse under the Code.

2.2 Principal Terms

(a) *Effective date* of this Plan means January 1, 2002.
(b) *Plan Year* means the 12-month period beginning January 1 and ending December 31.
(c) *Open Enrollment Period* means the period beginning approximately 60 days and ending approximately 30 days before the first day of each Election Period during

which a Participant or Employee can elect to enroll in the Plan and make elections in accordance with the terms of the Plan.

(d) *Medical Reimbursement Account* means the account described in Section 4.2 of this Plan.

(e) *Dependent Care Reimbursement Account* means the account described in Section 4.3 of this Plan.

(f) *Entry Date* means the first day of each Election Period.

(g) *Election Period* means the Plan Year for all Participant elections under the Plan with the exception of elections by Participants who participate in the System medical program for the premium conversion component of the Plan in which case the Election Period shall be the twelve (12) month period beginning each July 1 and ending each June 30.

(h) *Expense Period* means, solely with respect to the medical expense reimbursement component of the Plan, the twelve-month Plan Year.

(i) *Run-Out Period* means, solely with respect to the medical expense reimbursement and dependent care expense components of the Plan, the period ending 90 days after the end of the applicable Plan Year.

2.3 Construction

The masculine gender includes the feminine and the singular may include the plural, unless the context clearly indicates to the contrary. Headings of various Articles, sections and subsections of this document are inserted for convenience of reference and are not to be regarded as a part of this Plan or as controlling or indicating the meaning or construction of any provision. In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan, the provisions of this Plan as set forth herein shall be controlling.

Article 3. Eligibility and Participation

3.1 Initial Eligibility to Participate

An Employee shall be eligible to participate in the Plan immediately on his first day of employment. Rehired former Participants, after a separation of more than 30 days, are treated as new Employees under the Plan.

3.2 No Age Limitation

There is no minimum or maximum age requirement for participation in the Plan.

3.3 Duration

An Employee will become a Participant provided he has made an election, in writing or by some other legally acceptable method determined by the Administrator, to participate in accordance with Article 4. A Participant remains a Participant under the Plan until the earliest of:

(a) Termination of employment with the System;
(b) When the Participant no longer has an election in effect, as provided in Article 4;
(c) The termination of this Plan; or
(d) The date the Participant revokes his election to participate under a circumstance described as permitted by the terms of this Plan.

3.4 Claims Submission after Participation Ceases

If a Participant ceases to be a Participant, as provided in Section 3.3, he will still be allowed to submit claims against the balances in his Medical Reimbursement Account for qualified expenses incurred prior to the date participation ceased in accordance with the claims procedures set forth in Article 6. No reimbursements from the Participant's Medical Reimbursement Account will be permitted for expenses incurred after participation ceases, unless the Participant is eligible to elect COBRA continuation coverage (by having a positive account balance at the time of the COBRA qualifying event) and has properly elected COBRA coverage. Such COBRA coverage will cease at the end of the Election Period in which the qualifying event occurs.

If a Participant ceases to be a Participant, as provided in Section 3.3, he will still be allowed to submit claims against the balances in his Dependent Care Reimbursement Account for qualified expenses incurred through the end of the Plan Year in accordance with the claims procedure set forth in Article 6.

Article 4. Elections and Procedures

4.1 Benefit Elections Generally

Each Employee or Participant shall make benefit elections, in the manner provided in the Plan, to apply his or her salary reductions during each Election Period, in such proportions as he chooses, to the following:

(a) The Participant's premiums for Employer sponsored medical insurance, as set forth in Section 4.4 and 5.1(a). Any Participant who has elected to be covered by Employer-sponsored medical insurance shall be automatically enrolled in this Plan and shall be deemed to have elected to pay for the premiums for such coverage through salary reductions hereunder.

(b) Contributing to the Participant's Medical Reimbursement Account for that Election Period in accordance with Sections 4.2 and 5.2.

(c) Contributing to the Participant's Dependent Care Reimbursement Account for that Election Period in accordance with Sections 4.3 and 5.3.

An Employee's initial benefit election with respect to salary reductions to pay for the Participant's premiums for Employer-sponsored medical insurance shall be made as part of his or her application to participate and the election shall remain in effect until changed in accordance with the term of the Plan. An Employee may make a new election or change his benefit election for a subsequent Election Period by providing written notice to the Employer on an Employee Benefit Election Form during the Open Enrollment Period prior to the following Election Period for which such change is to be effective in accordance with rules prescribed by the Administrator.

4.2 Contributions to Medical Reimbursement Account

Prior to the first day of the applicable Election Period during which an Employee is eligible to participate, there will be an Open Enrollment Period during which the Employee can elect to reduce part of his compensation during the Election Period to make contributions to a Medical Reimbursement Account for qualified medical expenses from which the Employee as a Participant may request payment from the Plan's Claims Processor. The Employee can find an election form on the Employer's website, which may include the following information:

(a) That the election form must be completed and returned by the end of the Open Enrollment Period;
(b) that the election will be effective on the Entry Date and continue in effect until the last day of the Election Period during which the election is in effect;
(c) That, except as provided in Section 4.7, the election is not revocable;
(d) That, beginning in 2013, employees will be allowed to contribute, on a pre-tax basis, a maximum of $2,500 for their Medical Reimbursement Account FSA. After 2013, the $2,500 Medical Reimbursement Account maximum may be adjusted each year for inflation; and
(e) that the Participant will forfeit any unused dollars remaining in the Reimbursement Account at the end of the Election Period, subject to reimbursements available and carry-over provisions under Section 6.1.

In the case of new hires, participation is prorated for the remainder of the Election Period if work commences other than the first day of the first pay period of the Election Period.

4.3 Contributions to Dependent Care Reimbursement Account

Prior to the first day of the applicable Election Period during which an Employee is eligible to participate, there will be an Open Enrollment Period. During this period the Employee can elect to reduce part of his compensation during the Election Period to make contributions to a Dependent Care Reimbursement Account for qualified dependent care expenses from which the Employee as a Participant may request

payment from the Plan's Claims Processor. The Employee can find an election form on the Employer's website, which may include the following information:

(a) That the election form must be completed and returned to the Administrator by the end of the Open Enrollment Period;
(b) that the election will be effective on the Entry Date and continue in effect until the last day of the Election Period during which the election is in effect;
(c) That, except as provided in Section 4.7, the election is not revocable;
(d) that a Participant has the option of contributing, on a pre-tax basis, a maximum of $5000 ($2500 if the Participant is married and files a separate income tax return) or such other amount as may be provided by law for the Dependent Care Reimbursement Account; and
(e) that the Participant will forfeit any unused dollars remaining in the Reimbursement Account at the end of the Election Period, subject to reimbursements available under Section 6.1.

4.4 Premium Conversion Election

Prior to the first day of the applicable Election Period during which an Employee is eligible to participate, there will be an Open Enrollment Period during which the Employee can elect to participate in the Employer-sponsored medical insurance program. Any Participant who elects to participate in the Employer –sponsored medical insurance program shall be deemed to have elected to reduce part of his compensation during the Election Period to pay for the Employee's share of premiums to purchase medical insurance.

4.5 Failure to Make an Election

If an Employee fails to return the election form when first hired or when first eligible to participate in the Plan within 30 days, an Employee that has enrolled in the Plan will be deemed to have elected to reduce a portion of his compensation during the Election Period to pay the employee's share of premiums to purchase medical insurance, otherwise the Employee will not become a Participant during the Election Period, except in the case of certain status changes or changes in cost or coverage described in Sections 4.8 through 4.14 that permit a first-time election during an Election Period.

4.6 Annual Elections during Open Enrollment Period

Prior to the beginning of each subsequent Election Period there will be an Open Enrollment Period. During the Open Enrollment Period, an Employee who declined enrollment in a previous year will have an opportunity to make an election with respect to the Plan, and a Participant will have the opportunity to elect different or new options under the Plan effective for the next Election Period. If a Participant fails to return an election form and reelect previously elected premium conversion of his medical insurance premium and is still eligible to participate, the Participant will

be deemed to have elected a salary reduction amount necessary to provide the same coverage as he elected for the previous Election Period. However, a Participant electing a Medical or Dependent Care Reimbursement Account must actively re-elect each of these reimbursement accounts prior to each Election Period during the Open Enrollment Period in order for participation in these accounts to continue.

4.7 Irrevocability of Elections

Unless an exception described elsewhere in Article 4 applies, the Participant may not revoke or change any elections for the duration of the Election Period regarding participation in this Plan, salary reduction amounts of election, or election of particular component plan benefits. The Employer may limit a Participant's contributions in accordance with Section 4.17.

4.8 Change in Status

The Administrator will permit a revocation or change of an election during an Election Period, for the remainder of an Election Period, only if the revocation or new election is made on account of and consistent with a qualified Change in Status event, in accordance with a change in status as provided in Treasury Regulation § 1.125-4. The Participant must provide written notice to the Administrator of the qualified Change in Status event within 60 days of the event or as otherwise required under the underlying program. The Administrator, in its sole discretion, shall determine, based on IRS regulations and guidance, whether a requested change is on account of and corresponds with a Change in Status. An authorized change in the Participant's benefit election due to a Change in Status shall be effective immediately upon receipt of written notice. A change of status on account of the birth, adoption or placement of adoption of a dependent child may be made effective retroactively for up to 60 days. A change in status due to loss of eligibility for Medicaid or SCHIP coverage or gain of eligibility for a state premium assistance subsidy under the plan from Medicaid or SCHIP may be made for up to 60 days.

A qualified Change in Status event is any of the following:

(a) Legal Marital Status Changes: including marriage, death of Spouse, divorce, legal separation and annulment.
(b) Changes in Number of Dependents: including birth, death, adoption or placement for adoption.
(c) Employment Status Changes of the Employee, Participant or Spouse or Dependents: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave of absence, change of work-site or change in employment status that causes a loss or gain of eligibility under a plan.
(d) Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents: change in student status or dependent no longer eligible for benefits under a plan because of age, including, in accordance with IRS Notice 2010-38 and any amended regulations issued thereafter, nondependent children under the age of 27

becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

(e) Change in Residence: change in place of residence of the Employee, Participant, Spouse or Dependent that causes a gain or loss of eligibility under a plan.

For premium conversion and the Medical Reimbursement Account, an election change is consistent with the Change in Status only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan.

For the Dependent Care Reimbursement Account, an election change is consistent with the Change in Status only if the election change is on account of and corresponds with a change in status that affects expenses described in IRC Section 129.

Notwithstanding the foregoing, and solely for purposes of the premium conversion election based on an Employee's election to participate in the Employer-sponsored medical insurance program, a Change of Status shall also include, for the plan year ending in 2014, a change whereby an Employee who had elected to enroll in the Employer-sponsored medical insurance program has obtained coverage under a medical insurance program offered through a Federal or State "Exchange" or "Marketplace" offered in accordance with the Affordable Care Act. Any such Change of Status pursuant to this paragraph shall apply prospectively for the remaining portion of 2014.

The consistency rule of this Subsection shall be interpreted in accordance with IRS regulations and guidance and any other applicable law.

4.9 Special Enrollment Rights for Group Health Coverage under HIPAA

If an Employee, Participant, Spouse or Dependent is entitled to a special enrollment right under a group health plan as required by Code section 9801(f), then an Employee who previously declined coverage may make an election of premium conversion and a Participant may revoke a prior election for premium conversion and make a new election, provided that the election corresponds with such special enrollment right. A special enrollment right may arise if:

(a) Medical coverage was declined for the Employee, Spouse, or Dependent under the group health plan because of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or

(b) A Spouse is acquired as a result of marriage, or a Dependent is acquired as a result of birth, adoption, or placement for adoption.

(c) Medical coverage was lost under Medicaid or an SCHIP program due to loss of eligibility or eligibility was gained for a state premium assistance subsidy under Medicaid or SCHIP.

For purposes of this provision an election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right; and, a HIPAA special enrollment election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (for up to 60 days). An election to add or drop dependents as a result of gaining or losing coverage under a governmental program shall be consistent with the special enrollment right with proof of the event for up to 60 days.

4.10 Certain Judgments, Decrees and Orders

If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Dependent child, an Employee or Participant may (1) change his election to reflect coverage for the dependent child (provided that the order requires the Employee to provide coverage) or (2) change his election to reflect revocation of coverage for the Dependent child if the order requires that another individual (including the Spouse or former Spouse) provide coverage.

This Section 4.10 does not apply to the Dependent Care Reimbursement Account.

4.11 Medicare and Medicaid

If a Participant, Spouse or Dependent who is enrolled in a health or accident benefit plan becomes entitled to Medicare or Medicaid, the Participant may prospectively reduce or cancel his election to reflect the person becoming entitled to Medicare or Medicaid. Further, if an Employee, Participant, Spouse or Dependent loses eligibility for Medicare or Medicaid coverage, the Employee or Participant may change his election prospectively consistent with the loss of Medicare or Medicaid.

This Section 4.11 does not apply to the Dependent Care Reimbursement Account.

4.12 Institutional or Government-sponsored Health Programs

If an Employee, Spouse or Dependent loses eligibility for a State Children's Health Insurance Program (SCHIP), a program of the Indian Health Service or Indian tribal health program, a state health benefits risk pool or foreign government's health plan or similar government or institution-sponsored plan, the Employee may change his election prospectively consistent with the loss of coverage.

This Section 4.12 does not apply to the Dependent Care Reimbursement Account.

4.13 Cost Changes

If the cost of coverage of an Employer-sponsored plan described in Section 5.1 significantly increases or decreases, an Employee or Participant may choose to change his election consistent with such change. With respect to a Dependent Care Reimbursement Account under Section 4.3, a Participant may modify an election if the cost for services provided by a dependent care provider, who is not a relative of the Participant, increases or decreases.

This Section 4.13 does not apply to the Medical Reimbursement Account.

4.14 Coverage Changes

If coverage provided under a plan described in Section 5.1 is significantly curtailed, or ceases, a Participant who is covered under that plan shall be entitled to change his election consistent with such change.

If during a period of coverage, the System adds a new benefit plan or significantly improves an existing benefit plan a Participant may change his election accordingly. Similarly, an Employee who previously did not elect coverage may make a consistent mid-year election to enroll.

If the System eliminates an existing benefit plan option under Section 5.1, a Participant may make a consistent mid-year election.

A Participant may make a change in his election if such change is on account of and corresponds with a change in coverage made under another plan or another employer's plan if (a) such change is permitted under the other plan; or (b) the other plan permits participants to make an election for a period of coverage which is different from the Election Period under this Plan.

A Participant who separates from the service of the Employer during an Election Period may revoke his elections and terminate the receipt of benefits for the remaining portion of the Election Period. If the Employee should return to service within 30 days for the Employer during the same Plan Year, the Employee may re-enroll with the same benefit elections prior to termination for the remaining portion of the Election Period. If the Employee should return to service of the Employer after 30 days, but during the same Plan Year, the Employee may re-enroll with a new election for the remaining portion of the Election Period.

This Section 4.14 does not apply to the Medical Reimbursement Account,

4.15 Family and Medical Leave Act of 1993 (FMLA)

If a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the System will continue to maintain the Participant's health insurance plan benefits on the same terms and conditions as if the Participant were

still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the System will continue to pay its share of the premium.

A Participant may elect to continue his or her coverage under the premium payment and/or medical reimbursement account components of the Plan during the FMLA leave. If the Participant elects to continue coverage while on leave then the Participant may pay his or her share of the premium by either pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation, or paying on a pre-tax salary reduction basis out of compensation paid pursuant to accrued vacation pay (or other compensation that is payable to the Participant by the System) for all or a portion of the FMLA leave, or under another arrangement agreed upon between the Participant and the Administrator.

If the Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enroll in the Plan upon return from such leave on the same basis the Participant was participating in the Plan prior to the leave, or as otherwise required by law.

4.16 Insufficient Contributions

If a Participant does not elect a sufficient salary reduction amount with which to pay for the benefits the Participant elects under the Plan, the System is authorized to reduce the Participant's gross pay by the amount necessary to provide the benefits elected under the Plan.

4.17 Adjustments of Election Amounts by the Administrator

If, during the Election Period, the cost of Employer-sponsored benefit plans described in Article 5 that are elected by a Participant decreases and the decrease is insignificant or, if it increases and the increase is insignificant, the Administrator may automatically adjust the Participant's salary reduction amount, with respect to premium payments for that plan(s), to reflect such change.

The Administrator also maintains the right to adjust any salary reduction election made under this Plan, if necessary, to comply with any applicable laws and regulations, including any nondiscrimination requirements. A Participant shall not be permitted to change election amounts during an Election Period because of change in the cost of coverage, except as otherwise provided in Section 4.13.

Article 5. Benefits

5.1 Available Benefits

Salary reductions can be used to pay for:

(a) The Participant's required premiums for coverage under the System's medical insurance plans. The types and amounts of benefits and other terms and conditions of the benefits available under the medical insurance plans are set forth in those underlying benefit plans. All claims to receive benefits under those plans shall be subject to and governed by the terms and conditions of those plans and the rules, policies, and procedures adopted in accordance with those plans;
(b) Contributions to a Medical Reimbursement Account to reimburse the Participant for eligible non-covered medical expenses.
(c) Contributions to a Dependent Care Reimbursement Account to reimburse the Participant for eligible dependent care expenses.

5.2 Medical Reimbursement Accounts

A Participant may elect to make salary reduction contributions to an account for the payment of non-covered medical expenses incurred by the Participant, his Spouse and/or eligible Dependents.

Types of Eligible Medical Expenses: Reimbursements of non-covered medical expenses will only be made to specifically reimburse the Participant for medical expenses incurred during the applicable Election Period. Any dollars remaining in the Account after submission for all claims for reimbursement will be forfeited. The Participant may only obtain reimbursement of substantiated or receipted expenses that meet the criteria for deductibility as medical expenses under Code Section 213(d) or are incurred for drugs or medicine necessary to alleviate or treat personal injuries or sickness. These include, but are not limited to, non-covered medical expenses, vision and hearing expenses, non-covered dental expenses and prescription drug expenses. Expenses must be substantiated by a written statement from an independent third party describing the medical expense incurred, the date it was incurred and the amount of the expense. The Participant must provide a written statement that the amount has not been previously reimbursed and is not reimbursable from any other health plan. A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under the plans maintained by the Spouse's employer or individual policies maintained by the Participant and/or his Spouse or Dependents.

Reimbursement of the maximum dollar amount elected by the Participant (reduced by prior reimbursements) shall be available at all times during the period of coverage, regardless of the actual amounts deposited into the Participant's Medical Reimbursement Account.

5.3 Dependent Care Reimbursement Account

A Participant may elect to make salary reduction contributions to an account for the payment of eligible dependent care expenses incurred by the Participant and/or his Spouse.

Types of Eligible Dependent Care Expenses: Reimbursement of dependent care expenses will only be made to specifically reimburse the Participant and/or Spouse for dependent care expenses incurred during the applicable Election Period. Any dollars remaining in the Dependent Care Reimbursement Account after submission of all claims for reimbursement will be forfeited. The Participant may only obtain reimbursement of substantiated or receipted expenses that meet the criteria for deductibility under Code Sections 129(e) and 21(b)(2) including each of the following criteria (special rules consistent with Code Section 21(e)(5) apply to divorced parents or married individuals living apart):

(a) The expense is incurred by the Participant during a period when the Participant has either a dependent under age 13 for whom the Participant is entitled to an income tax deduction; or a dependent or spouse, regardless of age, who is incapable of caring for himself/herself and spends 8 or more hours each day in the Participant's household.
(b) The expense is for household services or for the care of the "qualifying individual" which enables the Participant to be gainfully employed.
(c) If the expense is for services provided outside the Participant's household at a Dependent Care Center, which provides care for at least six non-residents, it must comply with all state or local laws and charge a fee for providing the services.

5.4 When Eligible Expenses Are Incurred

In order to be reimbursed from the Medical Reimbursement Account, eligible expenses must have been incurred during the period the Participant was participating in the Plan. In order to be reimbursed from the Dependent Care Reimbursement Account, eligible expenses must have been incurred in the current Election Period covered by the benefit election. In general, expenses are treated as incurred at the same time that services are rendered, unless otherwise permitted by applicable IRS regulations or guidance. However, expenses incurred in the current Election Period may be submitted for reimbursement until 90 days after the Election Period ends. Actual reimbursement of the expenses may be made after the end of the Election Period.

5.5 No Trust Fund

In accordance with the Code and IRS guidance, the Reimbursement Accounts do not represent actual Participant or System deposits into any trust fund. No assets or funds will be held or invested in a separate trust. Participants are allocating dollars for medical and dependent care reimbursements from their account(s), which are treated as employer contributions under the Code. Until paid as reimbursements, the salary reduction contributions will remain part of the System's general assets.

Article 6. Payment of Claims

6.1 Notice of Reimbursements

Claims for reimbursements for medical expenses incurred during the Expense Period that are not otherwise covered under the System's medical insurance plans may be submitted at any time during the Expense Period and at any time within the Run-Out Period applicable to the Plan Year in which the Expense Period commenced, but no later than the end of such Run-Out Period. To the extent that any balance in the Participant's Medical Reimbursement Account exceeds the medical expenses incurred during the Expense Period, the remaining balance up to $500 may be carried forward to the next Expense Period to be used to pay or reimburse medical expenses incurred during the Expense Period to which such amount is carried over; provided, however, that such amount cannot be cashed-out or converted to any other taxable or nontaxable benefit.

Claims for reimbursement for dependent care expenses incurred during the Election Period may be submitted at any time during the Election Period and at any time within the Run-Out Period applicable to the Plan Year in which the Election Period commenced, but no later than the end of such Run-Out Period.

The Participant must file the claim on a form approved by the Administrator and must submit the claim to the System's Claim Processor for payment.

6.2 Ineligible or Terminated Employees

A Participant who has terminated employment or otherwise become ineligible to participate further in the Plan during an Election Period or, with respect to the medical expense reimbursement component of the Plan, during an Expense Period will be allowed to submit claims for reimbursement for expenses incurred during the Participant's period of participation until the applicable Run-Out Period ends. Notwithstanding the foregoing, the Participant's period of participation shall continue if, and for so long as, the Participant elects COBRA continuation coverage of the medical expense reimbursement component.

A Participant who has terminated employment or otherwise become ineligible to participate further in the Plan during an Election Period will still be allowed to submit claims against the balances in his Dependent Care Reimbursement Account for qualified expenses incurred through the end of the Plan Year in accordance with the procedure set forth in Section 6.1.

6.3 Appeal of a Denied Claim

If a claim for reimbursement from the medical reimbursement account or the dependent care expense account is wholly or partially denied, notice of the decision shall be furnished to the Participant within 90 days after receipt of the claim by the Plan. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be provided to the Participant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special

circumstances requiring an extension of time and the date by which the Plan expects to render the final decision. The following information must be provided in a written notice to the Participant denying a claim for benefits:

(a) Specific reason(s) for the denial;
(b) Specific reference to pertinent plan provisions on which the denial is based;
(c) A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
(d) Appropriate information as to the steps to be taken if the Participant wishes to submit his claim for review; and
(e) That the Participant or his duly authorized representative has a reasonable opportunity to appeal the denial of the claim, including but not limited to:

- Requesting a review upon written application to the Plan;
- Reviewing pertinent documents; and
- Submitting issues and comments in writing.

The Administrator's decision on the claim after the request to review the initial denial must be made 60 days after the Administrator receives the request for the review, unless special circumstances require an extension of time for processing, in which case the participant shall be notified of the extension and a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. The decision on review must be in writing and must include specific reasons for the decision, written in a manner calculated to be understood by the Participant, as well as specific references to the pertinent Plan provisions on which the decision is based. The above notwithstanding, the Administrator shall have the right to delegate the initial claim review to the Claims Processor. All appeals from the denial of the initial claim review will be reviewed by the Administrator.

6.4 Forfeitures

If, after the period for submitting claims has expired, as provided in Section 6.1, there remains an excess of dollars in either or both the Participant's Medical Reimbursement Account and Dependent Care Reimbursement Account, and after all timely-submitted claims have been paid out, then such excess shall be forfeited and returned to the System for disposition. Disposition by the System will take place by applying the forfeited amounts towards reducing administrative or other System expenses incurred in connection with making this Plan available to Employees.

Article 7. General Provisions

7.1 General Responsibility for Administration

The designated representatives of the System shall have only those specific powers, duties, responsibilities and obligations as are specifically granted to them under this Plan.

The System shall have the sole responsibility for the administrative costs of the Plan and shall have the sole authority to amend or terminate, in whole or in part, this Plan at any time.

The Administrator shall have the sole responsibility for the administration of this Plan which responsibility is specifically described in this Plan document.

7.2 Funding the Plan

All of the amounts payable under this Plan shall be paid from the general assets of the System. Nothing herein will be construed to require the System or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or any other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made.

There is no trust or other fund from which benefits are paid. While the System has responsibility for payment of benefits out of its general assets, it may hire an outside agent to make benefit payments on its behalf.

The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected for each benefit described under Article 5.

7.3 Appointment of Administrator

The System shall appoint an Administrator to administer the Plan. All usual and reasonable expenses of the Administrator may be paid in whole or in part by the System, and any expenses not paid by the System shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the System who is an Employee of the System shall not receive any compensation with respect to services rendered to the Plan except as such person may be entitled to benefits under this Plan.

7.4 Duties and Responsibilities of the Administrator

The Administrator must warrant that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing it for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, inquire into the propriety of any such direction, information, or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, and actions taken on behalf the System. Neither the Administrator nor the System makes any guarantee to any Participant in

any manner for any loss or other event because of the Participant's participation in this Plan.

The Administrator shall issue directions to the System concerning all benefits that are to be paid from the System's general assets pursuant to the provisions of the Plan, and warrant that all such directions are in accordance with the Plan.

7.5 Records and Reports

The Administrator shall exercise such authority and responsibility, as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances that are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the IRS for Section 125 Plans. At such periodic intervals as may be determined by the System, and after the close of each Election Period, the Administrator shall provide to each Participant a statement of his or her participation.

7.6 Other Powers and Duties of the Administrator

The Administrator shall have such duties and powers as may be necessary to discharge its responsibilities including, but not by way of limitation, the following:

(a) Construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits;
(b) Prescribe procedures to be followed by Participants filing application for benefits;
(c) Prepare and distribute, in such manner as the Administrator determines is appropriate, information explaining the Plan;
(d) Receive from the System and from Participants such information as shall be necessary for the proper administration of the Plan;
(e) Furnish the System, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
(f) Receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the System and reports of disbursements for expenses directed by the Administrator; and
(g) Appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including a claims processor, and legal and actuarial counsel.

The Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility under the Plan.

7.7 Rules and Decisions

The Administrator may adopt such rules for administration of the Plan, as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator shall

be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Administrator shall be entitled to rely upon information furnished by a Participant, the System or the legal counsel of the System.

7.8 Procedures

The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such bylaws and regulations, as it deems desirable for the conduct of its affairs.

7.9 Application and Forms for Benefits

The Administrator may require a Participant to complete and file with the Administrator an application for a benefit and all other forms approved by the Administrator, and to furnish all pertinent information requested by the Administrator. The Administrator may rely upon all such information so furnished, including the Participant's current address.

7.10 Entitlement to Payment and Discharge of Liability

Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit or installment is under an apparent legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the System to make payments to such person or to the person's legal representative or to a relative or friend of such person for such person's benefit, or the Administrator may direct the System to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment in accordance with the provisions of this Section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

7.11 Indemnification of the Administrator

The Administrator shall be indemnified by the System against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim.

7.12 Amendments and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the System reserves the right to make from time to time any amendment or amendments to this Plan, that the System determines necessary or desirable, with or without retroactive effect, including any amendment to comply with the law. The System may amend or terminate the Plan at any time. In the event

of the dissolution, merger, consolidation or reorganization of the System, the Plan shall terminate unless the Plan is continued by a successor to the System.

7.13 Effect of Plan Termination

Upon the termination of the Plan, the benefits of all Participants affected shall become payable as the Administrator may direct to the extent permitted by law.

7.14 Action by System.

Any action by the System under this Plan may be authorized by any person or persons duly authorized by the System to take such actions.

Article 8. Miscellaneous Provisions

8.1 No Contract of Employment

Nothing contained in this Plan shall be construed as a contract of employment between the System and any Employee, or as a right of any Employee to be continued in the employment of the System, or as a limitation of the right of the System to discharge any of its employees, with or without cause.

8.2 No Guarantee of Tax Consequences

Neither the Administrator nor the System makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes.

8.3 No Rights to System's Assets

No employee or beneficiary shall have any right to, or interest in, any assets of the System upon termination of employment or otherwise, except as provided under the terms of this Plan, and then only to the extent of the benefits as provided for in this Plan.

8.4 Non-assignability of Benefits

The right of any Participant to receive any benefits or reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to be taken by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized and shall be void, except to such extent as may be required by law. The System shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits.

8.5 No Divestment of Benefits

Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to a benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

IN WITNESS WHEREOF, the Pennsylvania State System of Higher Education has caused this Plan to be executed and its corporate seal attached thereto by its duly authorized officers on this 1ST day of OCTOBER, 2014.

By: _____

VICE CHANCELLOR FOR ADMINISTRATION AND FINANCE
Title

ATTEST:

By: Brenda A Mundell