May 13, 2020

REQUEST FOR PROPOSAL

ARIZONA BOARD OF REGENTS
REQUEST FOR PROFESSIONAL SERVICES
TO PROVIDE ADMINISTRATION OF THE
FLEXIBLE SPENDING ACCOUNT PROGRAM AND
BENEFITS BILLING AND COLLECTION FOR THE ARIZONA UNIVERSITY SYSTEM
RFP 2020004

DUE: 2:00 P.M. MST, THURSDAY, JUNE 11, 2020

Deadline for Inquiries	5:00 P.M., MST, THURSDAY, JUNE 4, 2020
Time and Date Set for Closing	2:00 P.M., MST, THURSDAY, JUNE 11, 2020

RFP SECTION INDEX

PROPOSAL ACKNOWLEDGEMENT RECEIPT

Request for Proposal number: RFP 2020004

Request for Proposal description: Administration of the flexible spending account program and benefits billing and collection.

Complete, sign, and submit this Proposal Acknowledgement Receipt to the Arizona Board of Regents at mary.adelman@azregents.edu.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-
Telephone Number		Fax Number
( ) -		( ) -
E-mail address, if available		
Print Name of Offeror's Authorized Agent		Signature of Offeror's Authorized Agent
Title of Authorized Agent		Date

SECTION A REQUEST FOR PROPOSAL

The Arizona Board of Regents (ABOR) is requesting sealed offers from qualified firms and/or individuals to provide administration of the flexible spending account program and benefits billing and collection for the Arizona university system.

Offers shall be received at the ABOR office located at *2700 N. Central Ave., Suite 850, Phoenix, AZ 85004* until **2:00 P.M., Arizona Local Time, on June 11, 2020** at which time a representative of ABOR shall announce publicly the names of those firms submitting Offers. No other public disclosure shall be made until after award of the Contract resulting from this Request for Proposal (RFP).

Any and all questions regarding this RFP shall be directed to Mary Adelman (Director, Administration) and to no other office or individual at ABOR. ABOR may answer informal questions orally. ABOR makes no warranty of any kind as to the correctness of any oral answers and uses this process solely to quickly provide minor clarifications. Oral statements or instructions shall not constitute an addendum to this RFP. Offeror shall not be entitled to rely on any verbal response from ABOR. Formal questions regarding any part of this RFP that may result in a material issue or a formal addendum must be submitted in writing. All correspondence regarding this RFP shall be directed to ABOR at:

Mary Adelman
Director, Administration
602-229-2523
mary.adelman@azregents.edu

SECTION B BACKGROUND INFORMATION

The Arizona Board of Regents (ABOR) is the governing body for Arizona State University (ASU), Northern Arizona University (NAU), and the University of Arizona (UA). The ABOR Executive Director and the university presidents report to a twelve-member Board of Regents that is appointed by the Governor of Arizona. Funding for the universities is obtained from state appropriations, local and sponsored funds. ABOR is legally, fiscally, and strategically responsible for these institutions. Additional information on ABOR may be accessed from the following link: http://azregents.edu/.

ABOR procurement policy requires all Contracts of this nature be re-bid no less than every five years. The initial Contract will be for a one-year period. ABOR shall have the right at its sole discretion, to renew the Contract for up to four one-year periods. Total Contract period not to exceed five years.

Flexible Spending Account Plan

Since April 1, 1991, ABOR has maintained a Dependent Care Account and a Health Care Account, both of which are Flexible Spending Accounts as described under Section 125 of the IRC. The plan documents can be found in Appendix A.

The Flexible Spending Account Plan is on a calendar year, January 1 – December 31.

1. Demographics

   Each university maintains a separate payroll system. The ABOR office uses the Arizona State University's payroll system.

   The data for the following information was collected for the pay period ending March 8, 2020. The total and average deduction per participant for one payroll for participants in:

   a) Health Care Account – $254,850.52 (average deduction – $236.46)
   b) Limited-Purpose Heath Care Account – $3,831.14 (average deduction -$137.13)
   c) Dependent Care Account – $154,070.50 (average deduction – $642.09)

	University of Arizona	*Arizona State University*	*Northern Arizona University*	*Board Office*	
Principal Location	Tucson	Tempe	Flagstaff	Phoenix	**Total**
Annual Payroll Deductions	24	26	26	26	
Benefits Eligible Employees	12,410	12,491	3,300	34	28,235
Dependent Care Participants	433	485	82	1	1,001
Health Care Participants	1,967	1,970	543	14	4,494
Limited-Purpose Health Care Participants	38	34	16	0	88
Total Count of Unique Participants	2,174	2,260	613	15	5,062
Total Participation Percentage	18%	18%	19%	44%	18%

2. 2020 Plan Year Maximums
   Dependent Care: $ 5,000
   Health Care: $ 2,650

3. Insurance Information
   University and ABOR employees and their qualified dependents may enroll in the medical, dental, and vision insurance plans offered through the State of Arizona Department of Administration. These benefits run on a calendar plan year. The State of Arizona offers a Health Savings Account (HSA) and the ABOR Flexible Spending Account plan offers a limited-purpose FSA to work with the State's HSA plan. Detailed information regarding co-pays, deductibles, and services covered can be found at:
   https://benefitoptions.az.gov/employees/enrollment-guides-rates.

   NAU's Summary of Benefits which also includes the NAU BCBS PPO and NAU BCBS HDHP w/HSA:
   https://in.nau.edu/wp-content/uploads/sites/5/2019/10/BN_BENEFITS_SUMMARY-2020.pdf

Each university offers specialty insurance plans to certain groups of employees.

University	Plan	Benefits eligible employees covered:	Information can be found:
ASU	International plan includes medical, dental, and air evacuation	Working outside the US	NA
NAU	Medical	All	https://in.nau.edu/human-resources/benefits-offered/
UA	Medical, dental and vision plans	With domestic partners	https://hr.arizona.edu/employees-affiliates/benefits/insurance-benefits/university-arizona-alternative-health-plans

Benefits Billing and Collections

ABOR/universities require a third-party administrator for insurance premium billing and collection for employees in an unpaid leave status on a bi-weekly, monthly or annual basis, as directed by ABOR/universities, for the following insurance premiums:

- Medical
- Dental
- Vision
- Supplemental life insurance
- Dependent life insurance
- Short term disability
- Health care flex spending account

Insurance premium payments are due within 30 calendar days of the billing date. The billing date should be calculated as the date of the billing of the begin date of the coverage period, whichever is later. ABOR/universities will require late notices and cancellation notices be sent by the administrator in addition to collecting payments from employees and remitting payments to ABOR/universities.

Currently NAU is using the benefits billing and collection service. NAU has about 300 retirees that pay an annual premium to a life insurance plan and 40 employees making monthly COBRA payments. This service will also be made available to ABOR, ASU and UA.

PROPOSAL BACKGROUND

1. RFP Overview
   ABOR invites proposals to provide professional services for 1) Third-Party Administrator for Flexible Spending Account (FSA) Program, including a Dependent Care Expense Reimbursement Program and a Health Care and Limited-Purpose Heath Care Expense Reimbursement Program and 2) Administrator for Benefits Billing and Collection Services.

2. Term
   Selected Offeror will be required to enter into a Contract with ABOR. The Contract shall not bind nor purport to bind ABOR for any Contractual commitment in excess of the original Contract period. ABOR shall have the right, at its sole discretion, to renew the Contract for up to four (4) one-year periods or a portion thereof. If ABOR exercises such rights, all terms, conditions, and provisions of the original Contract shall remain the same and apply during the renewal period except for costs charged.

3. Intent
   It is ABOR's intent to select the Offer(s), which are most favorable in all respects, including scope, availability of services, quality of services, reputation, and price. If not otherwise stated herein, multiple awards may be made or an award(s) may be made partial, by part, by line item, or by any combination of parts if identified as being in the best interest of ABOR.

4. Projected Timeline

May 13, 2020	RFP Release and Advertising
June 4, 2020	Deadline to Submit Questions
June 11, 2020	Proposal Due Date
June/July 2020	Committee Evaluation/Finalist Interviews
July 15, 2020	Award Contract
July 2020	Finalize Contract
August 2020	FSA Implementation
August 15, 2020	• Preliminary Communication and Open Enrollment Documents for FSA Due • Preliminary Benefits Billing and Collections Templates Due
September 1, 2020	• Final Communication and Open Enrollment Documents for FSA Due • Final Benefits Billing and Collections Templates Due
October 19, 2020	Commence Open Enrollment For FSA
November 6, 2020	End Open Enrollment for FSA
January 1, 2021	• Commence FSA Program for Plan Year 2021 • Commence Benefits Billing and Collection Services

SECTION C INSTRUCTIONS TO OFFERORS

1. All solicitations shall be performed under the direct supervision of ABOR Director, Administration and in accordance with board policies.

2. Offer shall be submitted in the format shown in Section D, Offer Format. Offers in any other format may be rejected. Conditional Offers shall not be considered. Offer must be signed by an authorized individual. An Offer that is not signed may be rejected.

3. Offers to be submitted as:

   3.1. One complete Offer, printed and bound, clearly marked as original; and

   3.2. Two copies of the complete Offer each on a separate electronic storage device.

4. Submit Offer sealed and marked as follows:

   Offeror's Name
   Offeror's Title
   RFP Number
   Date And Time Offer Is Due

5. No telephonic, electronic, or facsimile Offer shall be considered. Offers received after the date and time set for opening will be rejected. ABOR reserves the right to extend the time and date set for opening.

6. Any person, firm, corporation, and/or association submitting an Offer shall be deemed to have read and understood all the terms, conditions, and requirements specified herein.

7. Definitions:

   7.1. "Award" - means the earliest of: (a) issuance of a Notice to Proceed; (b) execution of a Contract between ABOR and the successful Offer(s); or (c) authorization to Contract provided by ABOR for such purpose.

   7.2. "Contract" - shall mean the agreement entered into between ABOR and the successful Offeror as a result of this RFP.

   7.3. "May" - indicates something that is not mandatory but permissible/desirable.

   7.4. "Offer" - shall mean the proposal from an individual or firm for the provision outlined in this RFP.

   7.5. "Offeror" - shall mean a person or firm submitting an Offer in response to this RFP.

7.6. “Shall”, “Must”, “Will” - indicate mandatory requirements. Failure to meet these mandatory requirements will result in rejection of Offer as non-responsive.

7.7. “Should” - indicates something that is recommended but not mandatory. If the Offeror fails to provide recommended information, ABOR may, at its sole option, ask the Offeror to provide the information or evaluate the Offer without the information.

8. Any information considered to be proprietary by the Offeror shall be placed in a separate envelope and marked "Proprietary Information". To the extent the ABOR Director, Administration concurs, this information shall be considered confidential and not public information. The ABOR Director, Administration shall be the final authority as to the extent of material, which will be considered confidential. Pricing information shall not be considered confidential.

9. Offer may be withdrawn at any time prior to the time and date set for opening.

10. Offer and accompanying documentation will become the property of ABOR at the time the Offer is opened.

11. ABOR reserves the right to cancel this solicitation, reject any or all Offers or any part thereof, or to accept any Offer or any part thereof and to waive or decline to waive irregularities in any Offer when it determines that it is in its best interest to do so. ABOR has the right to hold Offer for a period of ninety days after the opening date, the right to accept an Offer not withdrawn before the date set for opening, to negotiate with any Offeror considered qualified, or make any Award without written discussion.

12. ABOR reserves the right to conduct discussions and negotiations with the Offeror, to accept revisions to the Offer, and to negotiate price changes. ABOR shall not disclose any information derived from Offer or from discussions with other Offerors prior to Contract Award.

13. ABOR may request a presentation, demonstration, or samples be given to a selection committee. ABOR will schedule all presentations and in the event a presentation is scheduled, evaluation criteria and scoring may be included in the presentation invitation.

13.1. If presentation is to be held virtually, the Offeror will indicate format and information required to provide such presentation to the selection committee.

14. The Offeror may submit requests for changes or additions to ABOR terms and conditions set forth in Section F, Terms and Conditions. Any such changes must be submitted with the Offer as required in Section D, Offer Format, or the Offeror will have waived the right to object or add to ABOR’s terms and conditions. Additions may not be submitted as the Offeror’s standard terms and conditions, license agreement, or any other agreement, but rather as additional terms that do not conflict with ABOR’s terms and that are necessary for the success of the Contract. An Offer contingent upon changes or additions to ABOR

terms and conditions may, if ABOR at its sole discretion determines not to accept the alternate terms and conditions, be rejected as non-responsive.

15. By submitting an Offer, the Offeror agrees that any information provided within the Offer and accepted by ABOR shall become a binding part of a resulting Contract.

16. The successful Offeror(s) will be expected to enter into a Contract with ABOR. ABOR's terms and conditions shall be incorporated into the resulting Contract between ABOR and the successful Offeror.

17. ABOR is committed to the development of Small Business and Small Disadvantaged Business (SB & SDB) suppliers. If subcontracting is necessary, the Offeror shall make every effort to use SB & SDB in the performance of the Contract.

18. Requests for clarification of information shall be received no later than five working days prior to the time and date set for opening. If applicable, addenda shall be issued to each Offeror of record. Failure to request clarification within the timeframe will constitute a waiver of the right to object and shall not be grounds for a protest.

19. Any objections to alleged errors, irregularities, improprieties, specifications, or content shall be made prior to the time and date set for opening. Failure to object prior to the time and date set for opening will constitute a waiver of the right to object and shall not be grounds for a protest.

20. Failure to receive an addendum shall give Offeror the option of:

    20.1. Accepting the resulting Contract, if offered, including all addenda, at the proposed price.

    20.2. Withdrawing its Offer without penalty.

21. Failure to receive addenda shall not constitute a basis for claim, protest, or reissuance of the RFP.

22. Unless specifically stated to the contrary, manufacturer's names, trade names, brand names, or catalog numbers used in the specifications of this RFP shall be for the purpose of describing and/or establishing the quality, design, and performance required. Such reference shall not be intended to limit or restrict an Offer. Any Offer, which proposes like quality, design, and/or performance, shall be considered.

23. ABOR will not guarantee any minimum purchase volumes of any kind from the resulting Contract.

24. ABOR shall not reimburse the Offeror for costs associated with responding to this RFP.

25. Unless reasonable objection is made in writing as part of the Offer, the resulting Contract shall be for the use of all State of Arizona departments, agencies, commissions, and

boards. In addition, eligible municipalities, counties, universities, political subdivisions, and nonprofit educational or public health institutions may participate at their discretion. In order to participate in any resultant Contract, applicable entities must have entered into a cooperative purchasing agreement with either ABOR for and on behalf of the universities or the State of Arizona pursuant to A.R.S. § 41-2632.

26. ABOR treats Offerors in a fair, honest, and consistent manner by conducting the RFP process in good faith and by granting all Offerors a comparable opportunity to win an award. In the event the Offeror feels the process did not follow established policies and qualifies as an interested party, the Offeror may file a protest pursuant to ABOR procurement policy, Section 3-809. ABOR takes protests seriously and expects Offerors to do so as well. Frivolous protests shall not result in gain for the Offeror and shall not be considered.

27. Protests shall be received at the ABOR office located at 2700 N Central Ave, Suite 400, Phoenix, AZ 85004.

SECTION D OFFER FORMAT

In order to facilitate direct comparison, submit Offer using this format, listed in order, and index tabbed to match. Failure to follow instructions regarding format may result in rejection of Offer. Include the following with Offer:

1. Completed and signed Conflict of Interest Certification (refer to Section H).

2. Completed and signed Legal Worker Certification (refer to Section I).

3. Completed and signed Anti-Lobbying Certification (refer to Section J).

4. Completed and signed Federal Debarred List Certification (refer to Section K).

5. Completed and signed Participation in Boycott of Israel (refer to Section L).

6. Offeror's Qualifications and Experience (refer to Section E.1).

7. Project Resources (refer to Section E.2).

8. Client References (refer to Section E.3).

9. Description of Services/Method of Approach and Reporting Requirements (refer to Section E.4).

10. Performance Criteria (refer to Section E.5 and E.7)

11. Pricing Schedule (E.6).

12. Other Information (E.8).

13. Exceptions to the Terms and Conditions of the RFP (refer to Section F).

SECTION E REQUIREMENTS

The data, specifications, and requirements outlined herein are intended to serve as a general guideline for ABOR's requirements. Submit a fully detailed Offer that adequately describes the advantages and benefits to ABOR.

Provide a detailed response to each requirement in Section E, individually numbered to match each requirement. At a minimum, in such case where a detailed response is not applicable, indicate ability to comply with and/or agreement to the numbered requirement. The Offeror is encouraged to provide any additional information that is not specifically identified in this RFP. The response should be straightforward and limited to facts, solutions to problems, and plans for proposed action. The use of technical language should be minimized and used only to describe a technical process.

1. QUALIFICATIONS/EXPERIENCE

    1.1. Provide a corporate history/management summary and evidence that the Offeror and/or its officers have been engaged for a minimum of three years in providing similar products and services as described herein. Describe Offeror's growth for the past three years.

    1.2. Describe any restructuring, mergers, and/or downsizing that has occurred over the past three years or is anticipated in the next two years. If selected for negotiations, the Offeror may be required to provide the last two years of audited financial statements.

    1.3. Describe the material issues of any current legal actions against the Offeror including, but not limited to, parties of dispute, jurisdiction, and date of legal complaint.

    1.4. Detail experience with similar/like projects.

2. PROJECT RESOURCES

    2.1. Provide sufficient personnel, knowledge, and experience required to maintain an appropriate level of professionalism and coverage for performance of requirements outlined herein. ABOR reserves the right to review Offeror's staff assigned for relevant qualifications and experience.

    2.2. Offeror shall provide an organizational chart showing the staffing and lines of authority for the key personnel to be used in the implementation and ongoing management of the project. The relationship for the project leader to management.

    2.3. Provide a list of proposed personnel with resumes specifying qualifications and relevant experience. Describe assignment of account representatives and/or key personnel. and to support personnel should be clearly illustrated.

2.4. Offeror shall identify the location of the office that will handle the administration of the ABOR plans, how long this office has been in existence, and how many employers and participants are presently served by this office.

2.5. The Offeror will be required to conduct relevant and appropriate background checks and fingerprinting according to the ABOR policies on all assigned employees and new hires to ensure that it does not assign any employee or agent to ABOR who may reasonably be considered to pose a threat to the safety or welfare of the ABOR community, its property or its data. The Offeror will share background check information and other supporting documentation including disciplinary action for any employee upon written request by ABOR.

2.6. The Offeror may subcontract installation, training, warranty, or maintenance service with prior ABOR authorization. List and describe any subcontractor's qualifications and relevant experience. Describe how the Offeror guarantees subcontractor performance. The Offeror shall remain solely responsible for the performance of a resulting Contract from this RFP.

2.7. ABOR may request a tour of any administrative or service facilities intended to provide benefits stated in the proposal. Such a tour may include demonstrations of technical capabilities for recordkeeping, claim payment, customer service, etc., as well as interviews of staff intended to serve the university system. No fees will be paid by ABOR for such a tour and/or demonstration.

2.8. Provide a timeline and steps for implementation.

3. CLIENT REFERENCES

Provide, at minimum, three references identifying clients with requirements similar to those of ABOR, preferably located in Arizona. These references must be administered by the same office you intend to use for the services requested in this RFP. Provide the company name, contact person, address, email, telephone number and the number of employees covered by the services provided. ABOR reserves the right to contact additional references not provided by the Offeror. Preference may be given for those references, which are most similar to ABOR.

Offeror should list company, contact name, telephone number, and date of termination for companies terminating your services during the past three years.

4. DESCRIPTION OF SERVICES/METHOD OF APPROACH

Flexible Spending Accounts (FSA)

4.1. For the FSA plan ABOR/universities will:

4.1.1. Make regular deductions from salaries/wages for participants. Payroll deductions will occur during each payroll cycle and deductions will be taken in

arrears to ensure the elected annual reductions made. Payroll deduction data will be transmitted to the administrator at the close of each payroll period.

4.1.2. Forward enrollment and election data, i.e. university supplied identification number, annual salary reduction amount, etc., to the administrator for purposes of maintaining accurate financial records.

4.1.3. Develop a method of providing the administrator, on a pay period basis, the following listing through a university-preferred secure electronic method:

- All currently enrolled employees;
- All newly enrolled employees;
- All status changes; and
- All current deductions and/or adjustments.

4.1.4. Provide electronic information that ABOR/universities can give to employees describing coverage, necessary claim form procedures and other plan details.

4.1.5. Issue payment for administration fees on a monthly basis throughout the year, no later than 55 days after the first of the month or billing date, whichever is later.

4.1.6. Establish a method for issuing payments on a periodic basis, as agreed to by the administrator and ABOR/universities, for reimbursement of claim payments.

4.1.7. Provide a separate listing for adjustments (payments and credits) for persons not reported or inaccurately reported on the principal reports as needed. Net payments for such adjustments will be vouchered separately, and credits will be taken against subsequent payments. Administrator may not impose a deadline for such adjustments.

4.2. ABOR/universities will not certify eligibility for payment of the individual claims; it will be the responsibly of the administrator to certify eligibility for payment the individual claim.

4.3. Offeror shall administer the FSA plan as outlined below. Any required modifications to plan design or procedures must be fully described.

4.3.1. Review and recommend changes to ABOR's FSA plan document to conform to applicable laws. Offeror shall monitor and advise ABOR in a timely manner of any changes enacted by congress, the IRC or the state of Arizona that will affect the plan. The Offeror will assist ABOR and the universities with communicating these changes to participants.

4.3.2. Provide a sample of all participant communications.

4.3.3. Establish and implement an education program to increase awareness and participation in the FSA. Explain benefits and procedure to employee groups as requested by ABOR/universities. Provide a sample of your education materials.

4.3.4. Provide a representative to attend open enrollment meetings.

4.3.5. Offeror will pay for all claim forms, checks, employee booklets, HIPAA notices, COBRA notices, employee communications and all other forms on an ongoing basis.

4.3.6. Describe the claims procedures, processes and claims tracking. Offeror shall ensure payments to claimants are processed in a timely manner. Payment of a claim means the actual preparation and mailing of a check or processing for the direct deposit of the amount due to the participant. To facilitate timely payment, the Offeror shall:

- Provide clear, concise and complete claim processing instructions to participants specific to the ABOR FSA plan.
- Clearly state the mailing address, fax number, toll-free claims inquiry number and website on the claim form.
- Describe your telephone system, standard call waiting time and call abandonment rate.
- Describe your online claims submission process. Provide a sample online claims site for ABOR review.
- Describe your mobile application claim submission process.
- Describe your debit card capabilities and system limitations.
- Provide a toll-free line for claims inquiries, staffed 8 a.m. to 5 p.m. Arizona time (Arizona does not observe day light saving time) Monday through Friday exclusive of state holidays.
- Describe the appeals management and procedures for participant claims denied for payment.

4.3.7. Provide applicable plan year-end information to ABOR for completion of Forms 5500, if required.

4.3.8. Describe any problems you have recently encountered in administration of FSA plans.

4.4. Offeror shall understand and conform to the following:

4.4.1. Prepare the following materials and submit to ABOR/universities for preliminary review no later than August 1, 2020 and final documents for review no later than September 1, 2020.

- Participant plan information and communications describing the plan

- Open enrollment communication
- Claim form
- HIPAA Notices
- COBRA Notices
- Format and content of the Explanation of Benefits
- Format and content of participant account statements

4.4.2. Provide electronic copy of final claim form, instructions and participant plan information booklet to ABOR/universities on October 1, 2020.

4.4.3. Provide a website for participants on or before October 1, 2020.

4.4.4. Enrollment procedures will be completed annually or upon eligibility by all eligible employees who wish to redirect salary to a flexible spending account for the purposes of dependent care expense reimbursement and/or health care expense reimbursement. Describe your ability to provide these services electronically.

4.4.5. Conduct education programs prior to open enrollment and plan year end to promote and improve plan participation. Describe methods you have used to help clients increase participation in the FSA plan.

4.4.6. Maintain divisional security between ABOR and each university.

4.4.7. Claims may be submitted as frequently as desired by participants. The frequency of claims processing by the Offeror shall not be less than daily.

4.4.8. Describe how participant inquiries about account balances, denial of claims and other matters are handled.

4.4.9. The close of the plan year for purposes of submission of expenses incurred during the plan year is December 31. Dependent care and health care, including limited purpose health care, expense must be submitted by April 30, of the subsequent year, unless otherwise determined by the plan document or federal law.

4.4.10. The plan has adopted the $500 roll over for the health care FSA. Offeror must be able to work with the current administrator (ASIFlex) to accommodate participants with a rollover for plan year ending December 31, 2020.

4.4.11. A valid claim for processing shall be one that is accompanied by evidence that an allowable expense has been incurred.

4.4.12. Maintain an account and issue checks from this account on the Offeror's card stock. Cost of said check shall be included in the contractual per capita rate.

4.4.13. Checks shall be mailed as directed by the participant with accompanying explanation of benefits.

4.4.14. Participants must be able to select a direct deposit option. Evidence of the deposit shall be mailed via US mail, email or text as directed by the participant.

4.4.15. Participants must be given the option of a debit card, including the limited purpose health care participants.

4.4.16. Any applicable fees related to the debit card should be able to be paid by ABOR/university or by the participant as directed by ABOR and each university.

4.4.17. Quarterly account statements shall be issued to all participants via US mail or email as directed by the participant, on a timely basis, not to exceed four weeks after the close of the quarter.

4.4.18. Offeror shall maintain separate ledger account an shall provide a monthly report for ABOR and each university including beginning balance, current active and ending balance.

4.4.19. As prescribed under IRC Sections 105 and 129, the Offeror shall send participants statements via US mail or email, as directed by the participant, recapping all account activity for the previous tax year by January 31 of the subsequent year. This year end statement shall include a reminder to file all claims by the final submission date.

4.4.20. At the end of each plan year, the Offeror shall perform year-end accounting closeouts. A full report of accounting, including contributions, paid claims, and forfeitures must be furnished to ABOR and each university by June 30, following the plan year end.

4.4.21. A final cumulative accounting of all contributions and claims will be completed within six months of Contract termination.

4.4.22. Offeror shall perform all discrimination testing applicable to the plan as required under the IRC. Describe your ability to perform discrimination testing and the data required to perform this test.

4.4.23. All plan related data must be handled in a confidential and secure manner.

4.4.24. Upon enrollment the Offeror shall notify all participants of their COBRA options available upon separation.

4.4.25. After notification from ABOR/universities of a qualified separation, the Offeror shall notify the separated participant of the COBRA options available. Describe your COBRA administration procedures.

4.4.26. Offeror shall distribute the required HIPAA notification to all participants upon enrollment in the plan.

4.4.27. Offeror shall provide ABOR/universities with numerical, by university identification number, and alphabetical registers of reimbursements issued. These registered shall be provided to ABOR/universities as required, but no more often than once daily. Said document shall serve as authorization for ABOR/universities to transfer funds.

4.4.28. Offeror shall administer the plan in accordance with the current plan documents, federal tax guidelines and state statutes.

4.4.29. Offeror shall issue payment of 90% of all claims received shall be made within five working days of receipt (excluding dependent care claims for which there are insufficient funds available in the spending account). All claims shall be processed within twenty working days of receipt (excluding dependent care claims for which there are insufficient funds available in the spending account).

4.4.30. Offeror shall evaluate claims to determine if they have been properly filed and advise claimants, in writing, of the requirements for additional information and proper completion of claim forms. Furthermore, the Offeror shall notify claimants within five days of receipt of any delays or denied claims and the causes thereto and any steps necessary on behalf of the participant to rectify such claims.

Benefits Billing and Collections Services

4.5. ABOR/universities shall:

4.5.1. Provide on a bi-weekly, monthly or annual basis, via ABOR/university preferred electronic method, the following information for employees to be invoices.

- Employee name
- Employee university ID number
- Employee address
- Plan name to be billed

4.5.2. Accept only payments made in full

4.6. Offeror will be required to administer as outlined below. Any modifications in design or procedures shall be described.

4.6.1. Provide personalized and customized invoices, statements and other communications as needed or required by ABOR/universities. Provide a sample of all billing and collections communication.

4.6.2. Submit to ABOR/universities for approval all templates for invoices, statements and other communications expected to be sent by the Offeror by August 1, 2020. These templates should be specific to ABOR and each university and include the appropriate logo. and Submit final version of templates by September 30, 2020. Any changes made to these templates must be approved by ABOR/universities in advance of the change.

4.6.3. Pay for all billing and correspondence materials and postage on an ongoing basis.

4.6.4. Describe your invoice procedures to ensure that employees are billed in a timely manner. These procedures at a minimum should include:

- Prepare and mail a billing invoice or statement to the employee within 48 hours of receipt of the list of employees to be billed from ABOR/universities. Billing means the actual preparation and mailing of an invoice to the employee.
- Insurance premium payments are due within 30 calendar days of the billing date. The billing date should be calculated as the date the billing or the begin date of the coverage period, whichever is later.
- Distribute a late notice 15 calendar days prior to the cancellation notice.
- Issue a cancellation notice to employees whose premium payments are outstanding after the designated grace period.
- Remit only payments made in full to ABOR/universities.
- Provide electronic copies of the invoices or statements to ABOR/universities, upon request.
- Provide an alternative delivery option (email, website, etc.) as selected by the employee to receive invoices after initial billing.
- Provide clear, concise payment instructions including methods of payment and a remittance address. Methods of payment shall include:
    i. Personal Check
    ii. Bank Check
    iii. Cashier's Check
    iv. Money Order
    v. Debit Card
    vi. Credit Card

4.6.5. Describe your collection procedures in place to ensure the timely processing of payments, review of past invoices, and issuance of cancellation notices to employees who fail to remit the amount due within 30 calendar days.

4.6.6. Post and remit employee payments by ABOR and each university via check, wire or ACH, as preferred by ABOR and each university

4.6.7. Describe the administration access ABOR/universities will have. Provide detailed receipt/remittance information by ABOR or appropriate university for each employee including:

- Employee university ID number
- Employee name
- Plan name
- Premium amount received by plan
- Time period paid
- Date invoices
- Date due
- Date payment received

4.6.8. Provide to ABOR and/or each university a daily list of employees receiving cancellation notices including the date through which the last payment was made, and the dates of all prior notices sent.

4.6.9. Provide an electronic copy of all cancellation notices to ABOR or the appropriate university.

4.6.10. Describe any problems you have recently encountered in administering the requested billing and collection services.

5. PERFORMANCE CRITERIA

5.1. Offeror shall present proposed method of satisfying the requirements below.

5.1.1. Create and maintain files and institute and maintain control procedures necessary for the effective administration and conformance with applicable laws and regulations. All files created shall include both participant's name and university ID number as sort fields.

5.1.2. Assign a senior administrative representative who is authorized to answer questions from ABOR and the university benefits staff. Offeror shall respond to ABOR/university staff inquiries within one business day.

5.1.3. What mechanisms does Offeror have in place to prevent fraud by employees or plan participants? How does Offeror deal with fraud?

5.1.4. What procedures does Offeror have in place to limit the use or disclosure of Protected Health Information as required by Health Insurance Portability and Accountability Act (HIPAA)?

5.1.5. Describe the services used to monitor IRS and other regulations changes including but not limited to attorneys, tax services, etc. How has Offeror worked with clients to maintain plan compliance to these changes?

5.1.6. Describe procedures and safeguards for:

- Security of Offeror's hardware
- Authorized access to data
- Confidentiality of data
- Security for any hard copy of ABOR/university related data, documents and reports
- Retention and destruction of ABOR/university related data, documents and reports
- Disaster recovery
- Business continuity

5.1.7. Describe Offeror's telephone system, standard wait time and call abandonment rate.

6. PRICING SCHEDULE FOR SERVICES

6.1. Offeror shall submit a detailed cost proposal to include all aspects of providing the scope of work associated with this RFP. Cost proposal may be shown on the form attached as Exhibit C to this RFP or in a similar manner.

6.2. Flexible Spending Accounts - Provide by plan, i.e. Dependent Care Reimbursement Plan, Health Care Expense Reimbursement Plan, and combined plans, the cost to administer the plans identified by:

- The monthly fee per participating employee;
- Other fees, if any;
- Identify the components of other fees, (e.g. debit card, plan summary document, employee communications, forms etc.), again by separate plans and indicate which of these services may be stand-alone services.

6.3. Benefits Billing and Collections Administration

- Monthly fee.
- Other fees.
- Identify the components of other fees.

7. QUALITY ASSURANCE PLAN

Provide a quality assurance plan that details the methods by which the Offeror guarantees performance.

8. ADDITIONAL SERVICES

The Offeror may provide additional services that are not addressed herein. ABOR shall determine which additional service options are most beneficial from both a cost and service standpoint and may further negotiate these options to include or omit dependent on ABOR needs.

SECTION F TERMS AND CONDITIONS

The Offeror may submit requests for changes or additions to ABOR terms and conditions set forth in this Section F. Any such changes must be submitted with the Offer as required in Section D, or the Offeror will have waived the right to object or add to ABOR's terms and conditions. Additions may not be submitted as the Offeror's standard terms and conditions, license agreement, or any other agreement, but rather as additional terms that do not conflict with the ABOR's terms and that are necessary for the success of the Contract. An Offer contingent upon changes or additions to ABOR terms and conditions may, if ABOR at its sole discretion determines not to accept the alternate terms and conditions, be rejected as non-responsive.

1. **Remedies and Applicable Law.** This Contract shall be governed by and construed in accordance with the laws of the State of Arizona. ABOR and the Offeror shall have all remedies afforded by said law.

2. **Public Records.** The parties acknowledge that ABOR is subject to the provisions of the Arizona Public Records Laws, A.R.S. §§ 39-121 et. seq. In the event that a public records request is received by ABOR requesting records described as confidential, which ABOR determines must be disclosed, ABOR shall notify the other party prior to disclosure.

3. **Interpretation-Parol Evidence.** This writing shall be intended by the parties as a final expression of their Contract and shall be intended also as a complete and exclusive statement of the terms of their Contract. No course of prior dealings between the parties and no usage of the trade shall be relevant to supplement or explain any term used in this Contract. Acceptance or acquiescence in a course of performance rendered under this Contract shall not be relevant to determine the meaning of this Contract even though the accepting or acquiescing party has knowledge of the nature of the performance and opportunity for objection. Whenever a term defined by the Uniform Commercial Code is used in this Contract, the definition contained in the Code is to control.

4. **Dispute Resolution.** Except as otherwise provided herein, all Contract claims and controversies arising under this Contract shall be resolved pursuant to ABOR procurement procedures, Section 3-809, in particular Section 3-809(C).

5. **Equal Opportunity Clause.** The Offeror and any subcontractor(s) shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a), and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that the Offeror and any subcontractor(s) take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status, or disability.

6. **Non-Discrimination.** During the performance of this Contract, the Offeror agrees not to discriminate against any employee or applicant for employment because of race, color, sex, religion, or national origin, or because he or she has a disability, or because he or she

is a qualified protected veteran. The aforesaid provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The parties agree to comply with Arizona Executive Order 99-4, prohibiting discrimination in employment by government Contractors, to the extent applicable to this Contract.

7. **Family Education Rights and Privacy Act.** To the extent the Offeror will have access to student educational records, this paragraph will apply. Student educational records are protected by the federal Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g. The Offeror will comply with the Family Education Rights and Privacy Act and will not access or make any disclosures of ABOR's student educational records to third parties without prior notice to and consent from ABOR, or as otherwise provided by law.

8. **Health Insurance Portability and Accountability Act.** The Offeror shall abide by all laws and regulations that protect the privacy of healthcare information to which the Offeror obtains access under this Contract. The Offeror and ABOR acknowledge that certain portions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8, and the federal privacy regulations as contained in 45 CFR Part 164 may apply to the Offeror and ABOR, and their relationships and operation under this Contract. If necessary, the Offeror and ABOR will enter into a standard Business Associate Agreement and any other required Health Insurance Portability Accountability Act agreements. To the extent the terms thereof relate to the Offeror's performance under this Contract, the provisions of such Business Associate Agreement shall control.

9. **Americans with Disabilities Act and Rehabilitation Act.** The Offeror will comply with all applicable provisions of the Americans with Disabilities Act, the Rehabilitation Act, and all applicable federal regulations.

   All electronic and information technology and products and services to be used by ABOR staff, students, or other ABOR constituencies must be compliant with the Americans with Disabilities Act as amended and the Rehabilitation Act. Compliance means that a disabled person can acquire the same information, engage in the same interactions, and enjoy the same services as a nondisabled person, in an equally effective and integrated manner, with substantially equivalent ease of use.

   9.1. **Electronic and Information Technology**. Any acquisition considered electronic and information technology "EIT" as defined by the Access Board at 36 CFR 1194.4 and in the FAR at 2.101 must comply with Section 508 (36 CFR Part 1194) and requires the submission of a completed Voluntary Product Accessibility Template "VPAT" so that ABOR may ascertain conformance. Offers without a completed VPAT may be disqualified from competition.

      9.1.1. EIT is information technology "IT" and any equipment or interconnected system or subsystem of equipment that is used in the creation, conversion, or

duplication of data or information. EIT includes, but is not limited to:

9.1.1.1. telecommunication products, such as telephones;

9.1.1.2. information kiosks and transaction machines;

9.1.1.3. World Wide Web sites;

9.1.1.4. software;

9.1.1.5. multimedia (including videotapes); and

9.1.1.6. office equipment, such as copiers and fax machines.

9.1.2. ABOR reserves the right to perform real-world testing of a product or service to validate the Offeror's claims regarding Section 508 conformance. To facilitate testing the Offeror will, upon request, provide ABOR with access to the product being considered for purchase for a period of at least 30 calendar days.

9.2. **Services and Products.** An accessible service or product is one that can be used by as many people as possible, taking into account their physical, cognitive, emotional, and sensory differences.

9.2.1. Services provided include, but are not limited to:

9.2.1.1. education and training;

9.2.1.2. cultural and athletic events;

9.2.1.3. vehicle rentals;

9.2.1.4. event space and lodging; and

9.2.1.5. parking and transportation.

9.2.2. Products include, but are not limited to:

9.2.2.1. instructional materials;

9.2.2.2. office equipment;

9.2.2.3. office and classroom furniture; and

9.2.2.4. kiosks.

10. **Indemnification.** The Offeror shall indemnify, defend, save, and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers,

officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the Offeror or any of its owners, officers, directors, agents, employees, or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Offeror to conform to any federal, state or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the Offeror from and against any and all claims. It is agreed that the Offeror shall be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Offeror agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents, and employees for losses arising from services performed by the Offeror for the State of Arizona.

11. **Labor Disputes.** The Offeror shall give prompt notice to ABOR of any actual or potential labor dispute which delays or may delay performance of this Contract.

12. **Force Majeure.** Neither party shall be held responsible for any losses resulting if the fulfillment of any terms or provisions of this Contract are delayed or prevented by any cause not within the control of the party whose performance is interfered with, and which by the exercise of reasonable diligence, said party is unable to prevent.

13. **No Waiver.** No waiver by ABOR of any breach of the provisions of this Contract by the Offeror shall in any way be construed to be a waiver of any future breach or bar ABOR's right to insist on strict performance of the provisions of the Contract.

14. **Modifications.** This Contract shall be modified or rescinded only by a writing signed by both parties or their duly authorized agents.

15. **Assignment-Delegation.** No right or interest in this Contract shall be assigned or delegation of any obligation made by the Offeror without the written permission of ABOR. Any attempted assignment or delegation by the Offeror shall be wholly void and totally ineffective for all purposes unless made in conformity with this paragraph.

16. **Assignment of Anti-Trust Overcharge Claims.** The parties recognize that in actual economic practice overcharges resulting from anti-trust violations are in fact borne by the ultimate purchaser; therefore, the Offeror hereby assigns to ABOR any and all claims for such overcharges.

17. **Cancellation for Lack of Funding.** This Contract may be canceled without any further obligation on the part of ABOR in the event that sufficient appropriated funding is

unavailable to assure full performance of the terms. The Offeror shall be notified in writing of such non-appropriation at the earliest opportunity.

18. **Cancellation for Conflict of Interest.** In accordance with A.R.S. § 38-511, this Contract may be canceled without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting, or creating the Contract on behalf of ABOR shall, at any time while the Contract or any extension of the Contract shall be in effect, be an employee of any other party to the Contract in any capacity or a consultant to any other party of the Contract with respect to the subject matter of the Contract.

19. **Termination.** ABOR may terminate this Contract with or without cause upon 30 days written notice to the Offeror. If this Contract is terminated, ABOR shall have no further obligations other than payment for services already rendered and for expenses previously incurred.

20. **Insolvency.** ABOR shall have the right to terminate this Contract at any time in the event the Offeror files a petition in bankruptcy, or is adjudicated bankrupt; or if a petition in bankruptcy is filed against the Offeror and not discharged within 30 days; or if the Offeror becomes insolvent or makes an assignment for the benefit of its creditors or an arrangement pursuant to any bankruptcy law; or if a receiver is appointed for the Offeror or its business.

21. **Anti-Kickback.** In compliance with FAR 52.203-7, ABOR has in place and follows procedures designed to prevent and detect violations of the Anti-Kickback Act of 1986 in its operation and direct business relationships. As a party to the Contract, the Offeror is expected to comply with the Copeland "Anti-Kickback" Act (18 U.S.C. § 874) as supplemented in the Department of Labor regulations (29 C.F.R. Part 3). In as such this regulation applies to all Contracts and sub grants for construction or repair.

22. **Gratuities.** ABOR may, by written notice to the Offeror, cancel this Contract if it is found by ABOR that gratuities, in the form of entertainment, gifts or otherwise, were offered or given by the Offeror, or any agent or representative of the Offeror, to any officer or employee of the State of Arizona with a view toward securing a Contract or securing favorable treatment with respect to the awarding or amending, or the making of any determinations with respect to the performing of such Contract. In the event this Contract is canceled by ABOR pursuant to this provision, ABOR shall be entitled, in addition to any other rights and remedies, to recover or withhold the amount of the cost incurred by the Offeror in providing such gratuities.

23. **Inspection and Audit.** In accordance with A.R.S. § 35-214, the Offeror shall retain and shall Contractually require each subcontractor to retain all books, accounts, reports, files, and other records relating to this Contract for a period of five years after completion of this Contract. All records shall be subject at all reasonable times to inspection and audit by ABOR or the Auditor General of the State of Arizona, or their agents. Such records shall be produced at ABOR or such other location as designated by ABOR upon reasonable notice to the Contracting party.

24. **Insurance Requirements.** The Offeror may be requested to provide ABOR with a Certificate of Insurance prior to the commencement of services/Contract. The Offeror and subcontractors, without limiting any liabilities or any other obligations, shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract, are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Offeror, its agents, representatives, employees, or subcontractors.

    The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Offeror from liabilities that might arise out of the performance of the work under this Contract by the Offeror, its agents, representatives, employees, or subcontractors, and the Offeror is free to purchase additional insurance.

    ABOR reserves the right to request and receive certified copies of any or all of the following listed policies and/or endorsements within ten calendar days of Contract signature. Neither the Offeror's failure to provide, nor ABOR's failure to obtain proof of compliance shall act as a waiver of any term of this Contract.

    The Certificate of Insurance shall be from an insurance carrier lawfully authorized to do business in the State of Arizona, or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers and rated at least an A-, VII (7) in the current A.M. BEST RATINGS. The State of Arizona in no way warrants that the above required minimum insurer rating is sufficient to protect the Offeror from potential insurer insolvency. Coverage provided by the Offeror shall not be limited to the liability assumed under the indemnification provisions of this Contract. The Certificate shall include the following minimum insurance coverages:

    Commercial General Liability of $1,000,000 minimum combined single limit (CSL) each occurrence and $2,000,000 general aggregate, to include the following: Policy shall include bodily injury, property damage, personal injury, advertising injury and broad form Contractual liability coverage.

Each Occurrence	$1,000,000
Damage to Rented Premises	$ 50,000
Personal and Advertising Injury	$1,000,000
General Aggregate	$2,000,000
Products – Completed Operations Aggregate	$1,000,000

    Commercial Automobile Liability of $1,000,000 minimum combined single limit (CSL) each occurrence, to include either "ANY AUTO" or "SCHEDULED, HIRED, OWNED, NON-OWNED AUTOS".

    Professional Liability

Each Claim or Each Wrongful Act	$1,000,000

Annual Aggregate $2,000,000

In the event that the professional liability insurance required by this Contract is written on a claims-made basis, the Offeror warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two years beginning at the time work under this Contract is completed.

The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this Contract.

Workers' Compensation coverage for all employees which meets Arizona statutory benefits; including Employers Liability with minimum limits of $1,000,000 each accident, $1,000,000 each employee/disease, $1,000,000 policy limit/disease. Additional insured is not required.

Certificate Holder: The State of Arizona and ABOR shall be named as the certificate holder.

Additional Insured: The certificate shall name the State of Arizona and ABOR, its departments, agencies, boards, commissions, officers, officials, agents, and employees as additional insured on General and Automobile Liability, with respect to liability arising out of the activities performed by or on behalf of the Offeror. Such additional insured shall be covered to the full limits of liability purchased by the Offeror, even if those limits of liability are in excess of those required by this Contract.

Primary Coverage: The following statement shall be included: "The coverage afforded under this certificate shall be primary insurance with respect to all other available sources, except Workers' Compensation insurance. Any self-insurance or other insurance carried by the State of Arizona and ABOR, their officers, or employees, if any, shall be excess and not contributory to the insurance provided by the named insured."

Waiver of Subrogation: Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Offeror. The waiver of subrogation applies to Commercial General Liability, Commercial Auto Liability, and Workers' Compensation.

The following statement shall be included: Coverage afforded under these policies will not be canceled, terminated, or materially altered until 30 days prior written notice has been given to ABOR, with the exception of a 10 day notice of cancellation for non-payment of premium, any changes material to compliance with this Contract.

Description of project.

Material Breach: Failure on the part of the Offeror to meet these requirements shall constitute a material breach upon which the State of Arizona and ABOR may immediately

terminate this Contract, or, at its discretion, procure or renew such insurance and pay any and all premiums in connection therewith, and all monies so paid by the State of Arizona and ABOR shall be repaid by the Offeror to ABOR upon demand, or the State of Arizona and ABOR may offset the cost of the premiums against any monies due to the Offeror.

Costs for coverage broader than those required or for limits in excess of those required shall not be charged to the State of Arizona and ABOR.

25. **Sales and Use Tax.** The Offeror shall comply with and require all of his subcontractors to comply with all the provisions of the applicable state and sales excise tax law and compensation use tax law and all amendments to same. The Offeror further agrees to indemnify and save harmless ABOR, of and from any and all claims and demands made against it by virtue of the failure of the Offeror or any subcontractor to comply with the provisions of any or all said laws in amendments. ABOR is not exempt from state sales excise tax and compensation use tax.

26. **Changes.** Within the limits allowed by law, the Offeror agrees that ABOR may order additional services, or make changes by altering, adding to, or deducting from the proposed services, the Contract sum being adjusted accordingly, and the Offeror shall enter into a modification of the Contract to reflect said changes.

27. **Invoices.** Invoices will be emailed monthly accounting@azregents.edu. Invoices will be for all services delivered within the month. All invoices shall reference the Contract.

28. **Payment**. Payment shall be subject to the provisions of Title 35 of Arizona Revised Statutes relating to time and manner of submission of claims. Any obligation under this Contract shall be payable only and solely from funds appropriated for the purpose of the Contract.

29. **Personnel.** Employees of the Offeror assigned to the project and identified by name in the Contract shall remain dedicated to this project. Personnel changes shall be permitted only with prior notification and approval of ABOR.

30. **Independent Contractor.** It shall be understood that the Offeror shall operate as an Independent Contractor, not as an employee or agent of ABOR.

31. **Service Marks and Trademarks.** For purposes of this provision, the phrase "ABOR Mark" means any trade name, trademark, service mark, logo, domain name, and any other distinctive brand feature owned or used by ABOR. The Offeror agrees to comply with ABOR's trademark licensing program concerning any use or proposed use by the Offeror of any of ABOR Mark on goods, in relation to services, and in connection with advertisements or promotion of the Offeror or its business. Except as expressly authorized in this Agreement, the Offeror is not permitted to use any ABOR Mark without prior written approval of ABOR. Prior to any use of an ABOR Mark by the Offeror or its affiliates or successors or assigns, the Offeror will comply with ABOR's Licensing Policy.

32. **Advertising/Publishing.** The Offeror shall not advertise or publish, without ABOR's prior consent, the fact that ABOR had entered into this Contract, except to the extent necessary to comply with proper request for information provided by appropriate statues.

33. **Legal Workers.** Pursuant to A.R.S. § 41-4401, ABOR is prohibited after September 30, 2008 from awarding a Contract to any Offeror who fails, or whose subcontractors fail, to comply with A.R.S. § 23-214(A). The Offeror warrants that it complies fully with all federal immigration laws and regulations that relate to its employees, that it shall verify, through the U.S. Department of Homeland Security's E-Verify program, the employment eligibility of each employee hired after December 31, 2007, and that it shall require its subcontractors and sub-subcontractors to provide the same warranties to the Offeror.

    The Offeror acknowledges that a breach of this warranty by the Offeror or by any subcontractor or sub-subcontractor under this Contract shall be deemed a material breach of this Contract, and is grounds for penalties, including termination of this Contract, by ABOR. ABOR retains the right to inspect the records of any Offeror, subcontractor, and sub-subcontractor employee who performs work under this Contract, and to conduct random verification of the employment records of the Offeror and any subcontractor and sub-subcontractor who works on this Contract, to ensure that the Offeror and each subcontractor and sub-subcontractor is complying with the warranties set forth above. The portion of this provision dealing with the Offeror's warranty is not applicable where the Offeror is a governmental entity nor is the Offeror required to pass this provision through to subcontractors and sub-subcontractors who are governmental entities.

34. **Data Ownership.** ABOR will own, or retain all of its rights in, all data and information that ABOR provides to the Offeror, as well as all data managed by the Offeror on behalf of ABOR including all output, reports, analyses, and other materials relating to or generated by the services, even if generated by the Offeror, as well as all data collected, extracted, or received through ABOR's or the Offeror's use of the services or deliverables (collectively, the "ABOR Data"). ABOR Data shall be considered ABOR's confidential information. The Offeror shall not use, access, disclose, or license or provide to third parties, any ABOR Data, or any materials derived therefrom, except, in each case, as authorized in writing by ABOR. Without limiting the generality of the foregoing, the Offeror may not use any ABOR Data, whether or not aggregated or de-identified, for product development, marketing, profiling, benchmarking, or product demonstrations, without, in each case, ABOR's prior written consent.

35. **Non Disclosure and Trade Secrets.** The Offeror may receive (or has received) from ABOR and otherwise be exposed to confidential and proprietary information relating to ABOR's business practices, strategies, and technologies, ABOR Data as well as confidential information to ABOR necessary to perform the services and/or provide the deliverables (collectively, ABOR Confidential Information). ABOR Confidential Information may include, but not limited to, confidential and proprietary information supplied to the Offeror with the legend "ABOR Confidential and Proprietary" or other designations of confidentiality. As between the Offeror and ABOR, the ABOR Confidential Information is the sole, exclusive, and valuable property of ABOR. Accordingly, the Offeror will not reproduce or otherwise use any of the ABOR

Confidential Information except in the performance of the Services or the provision of the Deliverables and will not disclose any of the ABOR Confidential Information in any form to any third party, either during or after the Term, except with ABOR's prior written consent. Upon termination of the Contract, the Offeror will cease using and will return to ABOR, all originals and all copies of the ABOR Confidential Information, in all forms and media, in the Offeror's possession or under the Offeror's control. In addition, the Offeror will not disclose or otherwise make available to ABOR any confidential information of the Offeror or received by Contractor from any third party.

The Offeror will have no obligation to maintain as confidential any ABOR Confidential Information (other than ABOR Data) that the Offeror can show: (i) was already lawfully in the possession of or known by the Offeror before receipt from ABOR; (ii) is or becomes generally known in the industry through no violation of the Contract or any other agreement between the parties; (iii) is lawfully received by the Offeror from a third party without restriction on disclosure or use; (iv) is required to be disclosed by court order following notice to ABOR sufficient to allow ABOR to contest such order; or (v) is approved in writing by ABOR for release or other use by the Offeror.

36. **Payment Card Industry Data Security Standard.** For e-commerce business and/or credit card transactions, the Offeror agrees to be bound by the requirements and terms of the Rules of all applicable Card Associations, as amended from time to time and be solely responsible for security and maintaining confidentiality of Card transactions processed by means of electronic commerce up to the point of receipt of such transactions by Bank.

    The Offeror is required to be in compliance with the current or successor standard for Payment Card Industry Data Security Standard "PCI DSS", Payment Application Data Security Standard "PA DSS" for software and PIN Transaction Security "PCI PTS" for hardware and provide attestation of compliance annually. The technical solution must include the following:

    36.1. The Offeror maintains their own network operating on their own dedicated infrastructure. The Offeror's network includes a firewall that includes access control rules that separate the Offeror's PCI network from ABOR and restricts any communication between the Offeror's network devices and the ABOR systems.

    36.2. The Offeror treats the ABOR network as an untrusted network and encrypts all cardholder data traversing the ABOR network using industry standard encryption algorithms.

    36.3. A system where ABOR has no ability to decrypt cardholder data.

    36.4. Devices must be Secure Reading and Exchange of Data "SRED" and PTS 3.x compliant. Europay, MasterCard and Visa "EMV" compliance is required by October 1, 2015.

37. **Participation in Boycott of Israel.** Pursuant to A.R.S. §§ 35-393 and 35-393.01, the Offeror certifies that it is not currently engaged in and agrees, for the duration of the

Contract, to not engage in a Boycott of Israel. **Unless and until the District Court's injunction in *Jordahl v. Brnovich et al*., Case No. 3:17-cv-08263 (D. Ariz.) is stayed or lifted, the Anti-Israel Boycott Provision (A.R.S. § 35-393.01(A)) is unenforceable and the State will take no action to enforce it.**

38. **Essence of Time.** Time shall be of the essence as to matters contemplated by a resulting Contract under this RFP.

University Specific Terms and Conditions

Arizona State University

1. Green Purchasing requirements/Specifications

In order to reduce the adverse environmental impact of our purchasing decisions ASU is committed to buying goods and services from manufacturers and suppliers who share ASU's environmental concern and commitment. Green purchasing is the method wherein environmental and social considerations are taken with equal weight to the price, availability and performance criteria that we use to make purchasing decisions.

Proposer shall use environmentally preferable products, materials and companies where economically feasible. Environmentally preferable products have a less or reduced effect on human health and the environment when compared to other products and companies that serve the same purpose. If two (2) products are equal in performance characteristics and the pricing is within 5%, ASU will favor the more environmentally preferable product and company.

If you are citing environmentally preferred product claims, you must provide proper certification or detailed information on environmental benefits, durability and recyclable properties.

ASU and the supplier may negotiate during the Contract term to permit the substitution or addition of Environmentally Preferable Products (EPPs) when such products are readily available at a competitive cost and satisfy the ASU's performance needs.

Unless otherwise specified, proposers and Contractors should use recycled paper and double-sided copying for the production of all printed and photocopied documents. Furthermore, the documents shall be clearly marked to indicate that they are printed on recycled content (minimum 30% post-consumer waste) paper.

Proposer shall minimize packaging and any packaging/packing materials that are provided must meet at least one of, and preferably all, of the following criteria:

Made from 100% post-consumer recycled materials
Be recyclable
Reusable
Non-toxic
Biodegradable

Further, proposer is expected to pick up packaging and either reuse it or recycle it. This is a requirement of the Contract or purchase order.

2. Information Security

All systems containing ASU Data must be designed, managed, and operated in accordance with information security best practices and in compliance with all applicable federal and state laws, regulations and policies. To diminish information security threats, Vendor will (either directly or through its third-party service providers) meet the following requirements:

(a) Access Control. Control access to ASU's resources, including sensitive ASU Data, limiting access to legitimate business need based on an individual's job-related assignment. Vendor will, or will cause the system administrator to, approve and track access to ensure proper usage and accountability, and Vendor will make such information available to ASU for review, upon ASU's request.
(b) Incident Reporting. Report information security incidents immediately to ASU (including those that involve information disclosure incidents, unauthorized disclosure of ASU Data, network intrusions, successful virus attacks, unauthorized access or modifications, and threats and vulnerabilities).
(c) Off Shore. Direct services under this Contract will be performed within the borders of the United States. Any services that are described in this Contract that directly serve ASU and may involve access to secure or sensitive ASU Data or personal client data or development or modification of software for ASU will be performed within the borders of the United States. Unless stated otherwise in this Contract, this requirement does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of this Contract. This provision applies to work performed by subcontractors at all tiers and to all ASU Data.
(d) Patch Management. Carry out updates and patch management for all systems and devices in a timely manner and to the satisfaction of ASU. Updates and patch management must be deployed using an auditable process that can be reviewed by ASU upon ASU's request.
(e) Encryption. All systems and devices that store, process or transmit sensitive ASU Data must use an industry standard encryption protocol for data in transit and at rest.
(f) Notifications. Notify ASU immediately if Vendor receives any kind of subpoena for or involving ASU Data, if any third-party requests ASU Data, or if Vendor has a change in the location or transmission of ASU Data. All notifications to ASU required in this Information Security paragraph will be sent to ASU Information Security at Infosec@asu.edu, in addition to any other notice addresses in this Contract.
(g) Security Reviews. Complete SOC2 Type II or substantially equivalent reviews in accordance with industry standards, which reviews are subject to review by ASU upon ASU's request. Currently, no more than two reviews per year are required.
(h) Scanning and Penetration Tests. Perform periodic scans, including penetration tests, for unauthorized applications, services, code and system vulnerabilities on the networks and systems included in this Contract at regular intervals in accordance with industry

standards and best practices. Vendor must correct weaknesses within a reasonable period of time, and Vendor must provide proof of testing to ASU upon ASU's request.
(i) ASU Rights. ASU reserves the right (either directly or through third party service providers) to scan and/or penetration test any purchased and/or leased software regardless of where it resides.
(j) Secure Development. Use secure development and coding standards including secure change management procedures in accordance with industry standards. Perform penetration testing and/or scanning prior to releasing new software versions. Vendor will provide internal standards and procedures to ASU for review upon ASU request.

Northern Arizona University
1. Sustainability

NAU is committed to buying products with recycled content or environmentally sustainable alternatives. Identify environmentally sustainable features and supply relevant specifications of products Offered. Include information regarding Offeror's overall sustainable efforts.

2. Information Security.

The terms of this section apply if: 1) NAU is purchasing or leasing software, or processing a software renewal; 2) Supplier is creating any code for NAU; 3) Supplier receives, stores, or analyzes NAU Data (including if the data is not online); OR 4) Supplier is hosting, or managing by infrastructure outside of NAU, including any cloud-based systems, NAU Data.

All systems containing NAU Data must be designed, managed, and operated in accordance with information security best practices and in compliance with all applicable laws, rules, and regulations. To diminish information security threats, Supplier will (either directly or through its third-party service providers) meet the following requirements:

a. Access Control. Control access to NAU's resources, including sensitive NAU Data, limiting access to legitimate business need based on an individual's job-related assignment. Supplier will, or will cause the system administrator to, approve and track access to ensure proper usage and accountability, and Supplier will make such information available to NAU for review, upon NAU's request.

b. Incident Reporting. Report information security incidents immediately to NAU (including those that involve information disclosure incidents, unauthorized disclosure of NAU Data, network intrusions, successful virus attacks, unauthorized access or modifications, and threats and vulnerabilities).

c. Off-Shore. Direct Services that may involve access to secure or sensitive NAU Data or personal client data or development or modification of software for NAU, will be performed within the borders of the United States. Unless stated otherwise in the Agreement, this requirement does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the

Agreement. This provision applies to work performed by subcontractors at all tiers and to all NAU Data.

d. Patch Management. Carry out updates and patch management for all systems and devices in a timely manner and to the satisfaction of NAU. Updates and patch management must be deployed using an auditable process that can be reviewed by NAU upon NAU's request.

e. Encryption. All systems and devices that store, process or transmit sensitive NAU Data must use an industry standard encryption protocol for data in transit and at rest.

f. Notifications. Notify NAU immediately if Supplier receives any kind of subpoena for or involving NAU Data, if any third-party requests NAU Data, or if Supplier has a change in the location or transmission of NAU Data. All notifications to NAU required in this Information Security paragraph will be sent to NAU Information Security at Infosec@NAU.edu, in addition to any other notice addresses in the Agreement.

g. Security Reviews. Complete Service Organization Control 2 ("SOC2") Type II or substantially equivalent reviews in accordance with industry standards, which reviews are subject to review by NAU upon NAU's request. Currently, no more than two reviews per year are required.

h. Scanning and Penetration Tests. Perform periodic scans, including penetration tests, for unauthorized applications, services, code and system vulnerabilities on the networks and systems included in the Agreement in accordance with industry standards and NAU standards (as documented in NIST 800-115) or equivalent. All web-based applications (e.g. HTTP/HTTPS accessible URLs, APIs, and web services) are required to have their own web application security scan and remediation plan. Supplier must correct weaknesses within a reasonable period of time, and Supplier must provide proof of testing to NAU upon NAU's request.

i. NAU Rights. NAU reserves the right (either directly or through third party service providers) to scan and/or penetration-test any purchased and/or leased software regardless of where it resides.

j. Secure Development. Use secure development and coding standards including secure change management procedures in accordance with industry standards. Perform penetration testing and/or scanning prior to releasing new software versions. Supplier will provide internal standards and procedures to NAU for review upon NAU request.

University of Arizona

1. Information Security

All systems containing UA Data must be designed, managed, and operated in accordance with information security best practices and in compliance with all applicable federal and state laws, regulations and policies. To diminish information security threats, Licensor will (either directly or through its third-party service providers) meet the following requirements.

(a) **Access Control.** Control access to UA's resources, including sensitive UA Data, limiting access to legitimate business need based on an individual's job-related assignment. Licensor will, or will cause the system administrator to, approve and track access to ensure proper usage and accountability, and Licensor will make such information available to UA for review, upon UA's request.

(b) **Incident Reporting.** Report information security incidents immediately to UA (including those that involve information disclosure incidents, unauthorized disclosure of UA Data, network intrusions, successful virus attacks, unauthorized access or modifications, and threats and vulnerabilities).

(c) **Off Shore.** Direct services under this Agreement will be performed within the borders of the United States. Any services that are described in this Agreement that directly serve UA and may involve access to secure or sensitive UA Data or personal client data or development or modification of software for UA will be performed within the borders of the United States. Unless stated otherwise in this Agreement, this requirement does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of this Agreement. This provision applies to work performed by subcontractors at all tiers and to all UA Data.

(d) **Patch Management**. Carry out updates and patch management for all systems and devices in a timely manner and to the satisfaction of UA. Updates and patch management must be deployed using an auditable process that can be reviewed by UA upon UA's request

(e) **Encryption**. All systems and devices that store, process or transmit sensitive UA Data must use an industry standard encryption protocol for data in transit and at rest.

(f) **Notifications**. Notify UA immediately if Licensor receives any kind of subpoena for or involving UA Data, if any third-party requests UA Data, or if Licensor has a change in the location or transmission of UA Data. All notifications to UA required in this Information Security paragraph will be sent to UA Information Security at security@arizona.edu, in addition to any other notice addresses in this Agreement.

(g) **Security Reviews.** Complete SOC2 Type II or substantially equivalent reviews in accordance with industry standards, which reviews are subject to review by UA upon UA's request. Currently, no more than two reviews per year are required.

(h) **Scanning and Penetration Tests.** Perform periodic scans, including penetration tests, for unauthorized applications, services, code and system vulnerabilities on the networks and systems included in this Agreement at regular intervals in accordance with industry standards and best practices. Licensor must correct weaknesses within a reasonable period of time, and Licensor must provide proof of testing to UA upon UA's request.

(i) **University Rights**. UA reserves the right (either directly or through third party service providers) to scan and/or penetration test any purchased and/or leased software regardless of where it resides.

(j) **Secure Development**. Use secure development and coding standards including secure change management procedures in accordance with industry standards. Perform penetration testing and/or scanning prior to releasing new software versions. Licensor will provide internal standards and procedures to UA for review upon UA's request.

SECTION G EVALUATION CRITERIA

It is ABOR's intent to make an award to Offeror(s) that, in the opinion of ABOR, present Offers that appear to be favorable to ABOR, based upon the scope, availability of services, quality of services, reputation, and price offered. The criteria for evaluation of responses will be based on the following point structure:

1. Quality and performance of administration services, including claims and invoice processing. Capabilities to deliver electronic services to participants and ABOR/universities. Ability to provide ongoing communication and increase participating in the FSA plan (refer to Section E.4).
   40 Points

2. Performance criteria (refer to Section E.5, E.7 and E.8).
   25 Points

3. Offeror's qualifications and experience, project resources and client references (refer to Section E.1 – E.3)
   15 Points

4. Overall cost structure. (refer to section E.6)
   10 Points

5. Complete and signed certifications (Sections I – M).
   5 Points

6. Overall responsiveness to RFP.
   5 Points

SECTION H CONFLICT OF INTEREST CERTIFICATION

Date:

The undersigned certifies that to the best of his/her knowledge (check only one):

☐ There is no officer or employee of ABOR who has, or whose relative has, a substantial interest in any Contract resulting from this request.

☐ The names of any and all public officers or employees of ABOR who have, or whose relative has, a substantial interest in any Contract resulting from this request, and the nature of the substantial interest, are included below or as an attachment to this certification.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-
Telephone Number		E-mail address, if available
( ) -		( ) -
Print Name of Offeror's Authorized Agent		Signature of Offeror's Authorized Agent
Title of Offeror's Authorized Agent		Date

AN AUTHORIZED AGENT OF THE OFFEROR SHALL SIGN THE CONFLICT OF INTEREST CERTIFICATION

SECTION I LEGAL WORKER CERTIFICATION

Pursuant to A.R.S. § 41-4401, ABOR is prohibited after September 30, 2008 from awarding a Contract to any Offeror who fails, or whose subcontractors fail, to comply with A.R.S. § 23-214(A). The Offeror warrants that it complies fully with all federal immigration laws and regulations that relate to its employees, that it shall verify, through the U.S. Department of Homeland Security's E-Verify program, the employment eligibility of each employee hired after December 31, 2007, and that it shall require its subcontractors and sub-subcontractors to provide the same warranties to the Offeror.

The Offeror acknowledges that a breach of this warranty by the Offeror or by any subcontractor or sub-subcontractor under this Contract shall be deemed a material breach of this Contract, and is grounds for penalties, including termination of this Contract, by ABOR. ABOR retains the right to inspect the records of any Offeror, subcontractor and sub-subcontractor employee who performs work under this Contract, and to conduct random verification of the employment records of the Offeror and any subcontractor and sub-subcontractor who works on this Contract, to ensure that the Offeror and each subcontractor and sub-subcontractor is complying with the warranties set forth above. The portion of this provision dealing with the Offeror's warranty is not applicable where the Offeror is a governmental entity nor is the Offeror required to pass this provision through to subcontractors and sub-subcontractors who are governmental entities.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-
Telephone Number		E-mail address, if available
( ) -		( ) -
Print Name of Offeror's Authorized Agent		Signature of Offeror's Authorized Agent
Title of Offeror's Authorized Agent		Date

AN AUTHORIZED AGENT OF THE OFFEROR SHALL SIGN THE LEGAL WORKER CERTIFICATION

SECTION J ANTI-LOBBYING CERTIFICATION

Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions (Sept 2007). In accordance with the Federal Acquisition Regulation, 52.203-11:

(a) The definitions and prohibitions contained in the clause, at FAR 52.203-12, Limitation on Payments to Influence Certain Federal Transactions, included in this solicitation, are hereby incorporated by reference in paragraph (b) of this certification.

(b) The Offeror, by signing its offer, hereby certifies to the best of his or her knowledge and belief that on or after December 23, 1989.

(1) No Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with the awarding of this Contract;

(2) If any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with this solicitation, the Offeror shall complete and submit, with its offer, OMB standard form LLL, Disclosure of Lobbying Activities, to the Contracting Officer; and

(3) He or she will include the language of this certification in all subContract awards at any tier and require that all recipients of subContract awards in excess of $100,000 shall certify and disclose accordingly.

(c) Submission of this certification and disclosure is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, United States Code. Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision, shall be subject to a civil penalty of not less than $10,000, and not more than $100,000, for each such failure.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-

Telephone Number	E-mail address, if available
( ) -	( ) -
Print Name of Offeror's Authorized Agent	Signature of Offeror's Authorized Agent
Title of Offeror's Authorized Agent	Date

AN AUTHORIZED AGENT OF THE OFFEROR SHALL SIGN THE ANTI-LOBBYING CERTIFICATION

SECTION K FEDERAL DEBARRED LIST CERTIFICATION

Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (Dec 2001)

In accordance with the Federal Acquisition Regulation, 52.209-5:

(a) (1) The Offeror certifies, to the best of its knowledge and belief, that—
(i) The Offeror and/or any of its Principals—

(A) (check one) Are ( ) or are not ( ) presently debarred, suspended, proposed for debarment, or declared ineligible for the award of Contracts by any Federal agency; (The debarred list (List of Parties Excluded from Federal Procurement and Nonprocurement Programs) is at https://www.dol.gov/ofccp/regs/compliance/preaward/debarlst.htm).

(B) (check one) Have ( ) or have not ( ), within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) Contract or subContract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; and

(C) (check one) Are ( ) or are not ( ) presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in paragraph (a)(1)(i)(B) of this provision.

(ii) The Offeror (check one) has ( ) or has not ( ), within a three-year period preceding this offer, had one or more Contracts terminated for default by any Federal agency.

(2) "Principals," for the purposes of this certification, means officers; directors; owners; partners; and, persons having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment, and similar positions).

This Certification Concerns a Matter Within the Jurisdiction of an Agency of the United States and the Making of a False, Fictitious, or Fraudulent Certification May Render the Maker Subject to Prosecution Under Section 1001, Title 18, United States Code.

(b) The Offeror shall provide immediate written notice to the Contracting Officer if, at any time prior to Contract award, the Offeror learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(c) A certification that any of the items in paragraph (a) of this provision exists will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Offeror's responsibility. Failure of

the Offeror to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Offeror nonresponsible.

(d) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of an Offeror is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(e) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Offeror knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the Contract resulting from this solicitation for default.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-
Telephone Number		E-mail address, if available
( ) -		( ) -
Print Name of Offeror's Authorized Agent		Signature of Offeror's Authorized Agent
Title of Offeror's Authorized Agent		Date

AN AUTHORIZED AGENT OF THE OFFEROR SHALL SIGN THE FEDERAL DEBARRED LIST CERTIFICATION

SECTION L PARTICIPATION IN BOYCOTT OF ISRAEL

Unless and until the District Court's injunction in *Jordahl v.Brnovich et al*., Case No. 3:17-CV-08263 (D. Ariz.) is stayed or lifted, the Anti-Israel Boycott Provision (A.R.S. § 35-393.01(A)) is unenforceable and the State will take no action to enforce it. This attachment (Participation in Boycott of Israel) is not a mandatory part of the offer as long as the injunction remains in place. Offers will not be evaluated based on whether this certification has been completed.

Legislation has been enacted to prohibit ABOR from Contracting with firms currently engaged in a Boycott of Israel. To ensure compliance with A.R.S. §§ 35-393 and 35-393.01, this form to be completed and returned with the Offer.

By signing this form, the Offeror certifies that it is not currently engaged in and agrees, for the duration of the Contract, to not engage in a Boycott of Israel.

Name of Offeror		
Name of Contact		Title of Contact
Address 1		Address 2
City	State	Zip Code
		-
Telephone Number		E-mail address, if available
( ) -		( ) -
Print Name of Offeror's Authorized Agent		Signature of Offeror's Authorized Agent
Title of Offeror's Authorized Agent		Date

AN AUTHORIZED AGENT OF THE OFFEROR SHALL SIGN THE PARTICIPATION IN BOYCOTT OF ISRAEL

SECTION M PROPOSAL ATTACHMENTS

For Offeror's reference

ATTACHMENT A – SAMPLE AGREEMENT FOR CONSULTANT SERVICES

ATTACHMENT B – SCOPE/DESCRIPTION OF SERVICES

ATTACHMENT C – FEES FOR SERVICES

ATTACHMENT D – TERMS AND CONDITIONS

SECTION N ATTACHMENT A – SAMPLE AGREEMENT FOR CONSULTANT

SAMPLE AGREEMENT
ARIZONA BOARD OF REGENTS
AGREEMENT FOR CONSULTANT SERVICES

PARTIES: The Arizona Board of Regents ("ABOR"); and NAME ("CONSULTANT")

PURPOSE: ABOR is seeking an investment consultant for the retirement plans administered by ABOR.

1. ABOR desires to retain CONSULTANT, and CONSULTANT desires to provide services to ABOR, in his/her capacity as an independent Contractor, upon the terms and conditions set forth in this Agreement. CONSULTANT shall provide consulting services to ABOR in accordance with the Scope/Description of Services set forth in Exhibit A to this Agreement.

2. The Agreement is effective as of DATE and will extend to DATE, unless terminated earlier by either party. The parties may agree in writing to extend the Agreement.

3. Termination. ABOR may terminate this Agreement with or without cause upon 30 days written notice to the CONSULTANT. If this Agreement is terminated, ABOR shall have no further obligations other than payment for services already rendered and for expenses previously incurred.

4. CONSULTANT will not engage in any activity adverse to ABOR or the universities. CONSULTANT must disclose to ABOR any conflict of interest that arises during the course of this Agreement.

5. Services performed under this Contract will be performed by NAME, who will report to the ABOR Executive Director or designee.

6. Invoices will be emailed monthly to accounting@azregents.edu. Invoices will be for all items delivered within the month. All invoices shall reference the Agreement. Payments will be made in accordance with the fee schedule in Exhibit B.

7. For all purposes under the terms of this Agreement, CONSULTANT shall be an independent Contractor, and not an officer or employee of ABOR. ABOR shall provide no employee benefits, including but not limited to Workers' Compensation. In performance of the services described in this Agreement, the CONSULTANT shall determine his necessary hours of work.

8. The CONSULTANT shall maintain as confidential any and all confidential information, documents, materials, and items that CONSULTANT obtains, has access to, or is privy to

during the course of providing services to ABOR and the universities under this Agreement.

9. CONSULTANT may not assign the rights, delegate the duties, or otherwise dispose of any right, title, or interest in all or any part of any Contract, or assign any monies due or to become due to such CONSULTANT without the prior written consent of ABOR.

10. All reports and other work products produced by CONSULTANT as part of the services rendered under this Agreement shall be provided to and will be the sole property of ABOR. CONSULTANT shall not release such work product or other information obtained or produced pursuant to this Agreement without the prior written consent of ABOR.

11. CONSULTANT agrees to comply with all applicable laws, rules, regulations, and executive orders relating to nondiscrimination, equal employment opportunity, immigration, and the Americans with Disabilities Act.

12. The parties agree to submit all disputes under this agreement to this claims resolution procedures of ABOR Policy 3-809(C).

13. This Agreement may be cancelled without any further obligation on the part of ABOR in the event that sufficient appropriated funding is unavailable to assure full performance of its terms. CONSULTANT shall be notified in writing of any such non-appropriation at the earliest opportunity.

14. To the fullest extent allowed by law, CONSULTANT shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of CONSULTANT or any of the CONSULTANT'S owners, officers, directors, agents, employees, or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such CONSULTANT to conform to any federal, state or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by CONSULTANT from and against any and all claims. It is agreed that CONSULTANT will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Agreement, the CONSULTANT agrees to waive all rights of subrogation against ABOR, the State of Arizona, their officers, officials, agents, and employees for losses arising from the work performed by the CONSULTANT for ABOR and/or the State of Arizona.

15. CONSULTANT will maintain, until all of CONSULTANT's obligations have been discharged, insurance against claims that may arise from or in connection with the performance of the work performed by the CONSULTANT.

16. ABOR shall be permitted to retain other consultants performing similar tasks and services as the CONSULTANT, and the CONSULTANT shall be permitted to provide services to other parties consistent with the CONSULTANT's obligation to complete the services undertaken pursuant to the terms of this Agreement.

17. ABOR and CONSULTANT recognize that in actual economic practice overcharges resulting from antitrust violations are in fact borne by ABOR. Therefore, the CONSULTANT hereby assigns to ABOR any and all claims for such overcharges.

18. The parties agree that this Agreement may be cancelled for conflict of interest in accordance with Arizona Revised Statutes (A.R.S.) §38-511.

19. As required by A.R.S. §41-4401, ABOR is prohibited after September 30, 2008 from awarding a Contract to any Contractor who fails, or whose subcontractors/subrecipients fail, to comply with A.R.S. §23-214(A). CONSULTANT warrants that it complies fully with all applicable federal immigration laws and regulations that relate to its employees, that it shall, as applicable or required under A.R.S. §23-214(A), verify, through the employment verification pilot program as jointly administered by the U.S. Department of Homeland Security and the Social Security Administration or any of its successor programs, the employment eligibility of each employee hired to work on this Agreement, and that it shall, as applicable or required under A.R.S. §23-214(A), require its subcontractors and sub-subcontractors to provide the same warranties to CONSULTANT.

    A breach of the foregoing warranty shall be deemed a material breach of this Agreement. In addition to the legal rights and remedies available to ABOR hereunder and under the common law, in the event of such a breach, ABOR shall have the right to terminate this Agreement. Upon request, ABOR shall have the right to inspect the papers of each Contractor, subcontractor or any employee of either who performs work hereunder for the purpose of ensuring that the Contractor or subcontractor is in compliance with the warranty set forth in this provision.

20. As required by A.R.S. §§35-393 to 35-393.01, by executing this Agreement, CONSULTANT certifies it is not currently engaged in a boycott of Israel and will not engage in a boycott of Israel during the term of this Agreement. (Unless and until the District Court's injunction in *Jordahl v. Brnovich et al.* is stayed or lifted, the Anti-Israel Boycott Provision (A.R.S. §35-393.01(A)) is unenforceable and the State will take no action to enforce it.)

21. All books, accounts, reports, files, and other records relating to this Agreement shall be maintained and shall be subject at all reasonable times to inspection and audit by ABOR

for five years after completion of this Agreement. Records shall be produced at a place designated by ABOR, upon reasonable notice to the CONSULTANT.

Notice is provided of A.R.S. §§ 12-1518 and 12-133.

Failure by CONSULTANT to perform as specifically provided herein shall be an event of default permitting ABOR to pursue all remedies affordable by law or in equity, including termination of this Agreement.

CONSULTANT shall address all notices (excluding reimbursement claims) relative to this Agreement to:

ABOR shall address all notices relative to this Agreement to:

22. CONSULTANT shall comply with Section F "Terms and Conditions" of this RFP 2020004, which are attached to this Agreement as Exhibit C and incorporated herein by reference.

23. This Agreement constitutes the entire agreement and understanding of the parties with respect to its subject matter. No prior or contemporaneous agreement or understanding will be effective.

    This Agreement may not be modified or amended except by written instrument signed by both parties.

    This Agreement shall be governed by the laws of Arizona, the courts of which shall have jurisdiction over its subject matter.

24. The individual signing below on behalf of CONSULTANT hereby represents and warrants that he is duly authorized to execute and deliver this Agreement on behalf of CONSULTANT and that this Agreement is binding upon CONSULTANT in accordance with its terms.

This Agreement may be executed in counter parts.

ARIZONA BOARD OF REGENTS	**CONSULTANT**
By_____	By_____
Date:_____	Date:_____

SECTION O ATTACHMENT B – SCOPE / DESCRIPTION OF SERVICES

SAMPLE
EXHIBIT A
TO ABOR
AGREEMENT FOR CONSULTANT SERVICES

SCOPE / DESCRIPTION OF SERVICES

CONSULTANT will provide the following services:

SECTION P ATTACHMENT C – FEES FOR SERVICES

SAMPLE
EXHIBIT B
TO ABOR
AGREEMENT FOR CONSULTANT SERVICES

FEES FOR SERVICES

SAMPLE
EXHIBIT C
TO ABOR
AGREEMENT FOR CONSULTANT SERVICES

TERMS AND CONDITIONS
(RFP 2020004, Section F)

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

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

Table of Contents

ARIZONA BOARD OF REGENTS
HEALTH AND DEPENDENT CARE CAFETERIA PLAN

As Amended and Restated Effective January 1, 2010

ARTICLE I. Introduction

1.1 Establishment of Plan

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

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

1.2 Legal Status

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

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

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

ARTICLE II. Definitions

2.1 Definitions

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

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

"Board" means the Arizona Board of Regents.

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

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

"**Change in Status**" has the meaning described in Section 12.3.

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

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

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

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

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

"**DCAP**" means dependent care assistance program.

"**DCAP Account**" means the account described in Section 9.5.

"**DCAP Benefits**" has the meaning described in Section 9.1.

"**DCAP Component**" means the Component of this Plan described in Article IX.

"**Dependent**" means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component, (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 9.3(c). Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"**Dependent Care Expenses**" has the meaning described in Section 9.3.

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

"**Effective Date**" of this Plan, as amended and restated, means January 1, 2010.

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

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

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

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

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

"**EPO**" means a self-insured exclusive provider organization.

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

"**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

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

"**Group Term Life Insurance Benefits**" means the Employee's Group Term Life Insurance Plan coverage for purposes of this Plan.

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

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

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

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

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

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

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

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

"**Health FSA Account**" means the account described in Section 7.5.

"**Health FSA Benefits**" has the meaning described in Section 7.1.

"**Health FSA Component**" means the Component of this Plan described in Article VII.

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

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

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HMO**" means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

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

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

"**Medical Insurance Benefits**" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

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

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

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

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

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

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

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

"**PPO**" means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

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

"**Premium Payment Component**" means the Component of this Plan described in Article VI.

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

"**Qualifying Dependent Care Services**" has the meaning described in Section 9.3.

"**Qualifying Individual**" has the meaning described in Section 9.3.

"**Qualified Reservist Distribution**" means a distribution to a reservist as described in Section 7.9.

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

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

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

"University" or "Universities" refers to Arizona State University, the University of Arizona and Northern Arizona University.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

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

3.2 Termination of Participation

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

- the termination of this Plan; or

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

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

3.3 Participation Following Termination of Employment or Loss of Eligibility

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

3.4 FMLA Leaves of Absence

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

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

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

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

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

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

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

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

3.5 Non-FMLA Leaves of Absence

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

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible

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

4.2 Elections During Open Enrollment Period

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

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

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

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

4.4 Irrevocability of Elections

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

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

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

(a) Premium Payment Benefits, as described in Article VI.

(b) Health FSA Benefits, as described in Article VII. The Health FSA election may be for:

- A General-Purpose Health FSA Option; or
- If the Participant has elected to participate in an HSA offered by an Employer under an HSA program outside this Plan, a Limited (Vision/Dental/Preventive Care) Health FSA Option.

(c) DCAP Benefits, as described in Article IX.

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

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* For Participants who elect Medical Insurance Benefits or Group Term Life Insurance Benefits described in Article VI, the Employer will contribute a portion, if any, of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. There are no Employer contributions for Health FSA Benefits or DCAP Benefits.

(b) *Participant Contributions.* Participants who elect any of the Medical Insurance Benefits or Group Term Life Insurance Benefits described in Article VI, Health FSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

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

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date

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

5.4 Funding This Plan

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

ARTICLE VI. Premium Payment Component

6.1 Benefits

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

6.2 Contributions for Cost of Coverage

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

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan

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

6.4 Medical Insurance Benefits; COBRA

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

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

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

7.2 Contributions for Cost of Coverage of Health FSA Benefits

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

7.3 Eligible Medical Care Expenses for Health FSA

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

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

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

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

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

7.4 Maximum and Minimum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $5,000.00, subject to Section 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

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

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII (other than under Section 12.4(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 12.4(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

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

7.5 Establishment of Health FSA Account

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

(a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

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

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

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

(b) *Use of Forfeitures.* All forfeitures under this Plan shall be retained by the Employer and the Participants shall have no claim thereto. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit

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

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.* Within 30 days after receipt by the Employer (or such third-party administrator who may be administrating this Plan on behalf of the Plan Administrator or Employer(s)) of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Employer approves the claim), or the Employer will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Employer, including in cases where a reimbursement claim is incomplete. The Employer will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Employer in such form as the Employer may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Employer in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

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

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

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

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

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

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

7.9 Coordination of Benefits

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

7.10 Qualified Reservist Distributions

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

- The Participant's contributions to his or her Health FSA Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution exceed the reimbursements he or she has received from his or her Health FSA Account for the Plan Year as of that date.

- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

- The Participant has provided the Employer (or its designee) with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

- The Participant is ordered or called to active military duty on or after April 1, 2009, or his or her period of active duty begins before April 1, 2009 and continues on or after that date.

- During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant delivers a written election to the Employer (or its designee) in such form as the Employer may prescribe, requesting a Qualified Reservist Distribution.

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

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

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

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

ARTICLE VIII. HSA Benefits

8.1 HSA Benefits Provided Through Other Plans

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

8.2 Health FSA Benefits Coordinated With HSA Benefits

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

ARTICLE IX. DCAP Component

9.1 DCAP Benefits

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

9.2 Contributions for Cost of Coverage for DCAP Benefits

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

9.3 Eligible Dependent Care Expenses

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

(a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.

(c) *Qualifying Individual.* "Qualifying Individual" means:

- a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);

- a tax dependent of the Participant as defined in Code § 152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)(3)(A)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

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

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

- in the Participant's home; or

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

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

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;

- a Participant's Spouse; or

- a Participant's child (as defined in Code § 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred.

9.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article IX have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is

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

- the Participant's Earned Income for the calendar year;

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

- either $5,000 or $2,500 for the calendar year, as applicable:

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

  - the Participant is married and files a joint federal income tax return;

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

  - the Participant is single or is the head of the household for federal income tax purposes; or

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

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

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

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

9.5 Establishment of DCAP Account

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

(a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount. A*s described in Section 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

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

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

9.7 Reimbursement Claims Procedure for DCAP

(a) *Timing.* Within 30 days after receipt by the Employer (or such third-party administrator who may be administrating this Plan on behalf of the Plan Administrator or Employer(s)) of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Employer approves the claim), or the Employer will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Employer, including in cases where a reimbursement claim is incomplete. The Employer will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Employer in such form as the Employer may prescribe, by no later than the April 30 following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and

- other such details about the expenses that may be requested by the Employer in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

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

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

9.8 Reimbursements From DCAP After Termination of Participation

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

9.9 Report to DCAP Participants

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

ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article X:

> *Protected Health Information.* Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

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

10.3 Permitted Uses and Disclosure of Summary Health Information

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

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

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

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

processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

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

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

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

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Plan Administrator shall allow the following persons access to PHI: the Executive Director of the Board; the Human Resource Directors of the Universities; such staff of the Board or the Universities designated by the Executive Director or Human Resource Directors identified above who need access to PHI in order to perform administrative functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals); and any other Employee who needs access to PHI in order to perform Plan administration functions. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures. The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

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

ARTICLE XI. [Reserved]

ARTICLE XII. Irrevocability of Elections; Exceptions

12.1 Irrevocability of Elections

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

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

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

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 12.4(d) through 12.4(i), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only. As specified by the Employer, the election changes for the Employer's group of Employees will become effective as of the first day of the calendar month following the date the election change was filed or the first day of the first payroll period following the date the election change was filed; provided that, as determined by the Employer, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later.

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 9.4 respectively.

12.3 Change in Status Defined

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

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence (other than mandatory furlough days imposed on the Participant by his or her Employer from time-to-time); (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

12.4 Events Permitting Exception to Irrevocability Rule for All Benefits

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

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

(b) *Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) *Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

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

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

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

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

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Employer may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Employer has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

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

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

(f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her

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

(h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 12.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an EPO, HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Employer, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Employer, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Employer determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Employer determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance

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

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 12.4(h)(1) through 12.4(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 12.4(h) applies also to this Section 12.4(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Employer in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Employer determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides

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

(b) *Significant Curtailment With a Loss of Coverage*. If the Employer determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 12.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Employer, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Employer may permit the following election changes: (a) Participants who

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

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes

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

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

12.5 Election Modifications Required by Plan Administrator

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

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

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

13.2 Claims Procedures for Medical and Group Term Life Insurance Benefits

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

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

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

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

14.2 Powers of the Plan Administrator

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

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including third-party administrators, legal counsel and benefit consultants;

(h) to delegate to an Employer such powers and duties as may be necessary to administer this Plan as specifically provided or contemplated herein;

(i) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(j) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(k) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

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

14.4 Provision for Third-Party Plan Service Providers

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

14.5 Fiduciary Liability

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

14.6 Insurance Contracts

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

14.7 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems

administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 Expenses

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

15.2 No Contract of Employment

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

15.3 Amendment and Termination

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

15.4 Governing Law

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

(a) In administrating this Plan, the Board and Employers will comply with all applicable state and federal laws, rules, regulations and executive orders governing equal employment opportunity, immigration, nondiscrimination, including the Americans with Disabilities Act, and affirmative action.

(b) As provided in A.R.S. section 38-511, this Plan or any of the administrative contracts hereunder may be canceled if any person significantly involved in initiating, negotiating, securing, drafting or creating this Plan or any contract on behalf of the Board of an Employer is an employee, consultant, or agent of any other party to such contract.

(c) The Board, the Employers and any other party providing services under this Plan are given notice of and are bound by the arbitration provisions of A.R.S. sections 12-1518 and 12-133.

(d) Pursuant to A.R.S. section 35-397, any person providing services under this Plan certifies that is does not have a scrutinized business operation in either Sudan or Iran.

(e) As required by A.R.S. section 41-4401, the Board or any Employer is prohibited after September 30, 2008 from awarding a contract to any service or construction contractor who fails, or whose subcontractors fail, to comply with A.R.S. section 23-214-A. Any person to whom a contract may be awarded under this Plan ("Contractor") warrants that it complies fully with all federal immigration laws and regulations that relate to its employees, that it shall verify, through the employment verification pilot program as jointly administered by the U.S. Department of Homeland Security and the Social Security Administration or any of its successor programs, the employment eligibility of each employee hired after December 31, 2007, and that it shall require its subcontractors and sub-subcontractors to provide the same warranties to the Contractor. The Contractor acknowledges that a breach of this warranty by the Contractor or by any subcontractor or sub-subcontractor providing services under this Plan shall be deemed a material breach of this Plan, and is grounds for penalties, including termination by the Board of an Employer of any contracts whereby the Contractor provides services hereunder. The Board and Employers retain the right to inspect the records of any Contractor, subcontractor and sub-subcontractor employee who performs services under this Plan, and to conduct random verification of the employment records of the Contractor and any subcontractor or sub-subcontractor who provides services under this Plan, to ensure that the Contractor and each subcontractor and sub-subcontractor is complying with the warranties set forth above. The Contractor shall be responsible for all costs associated with compliance with this requirement.

(f) The to the extent required by A.R.S. section 35-214, the Employers and anyone providing services under this Plan agree to retain all records relating to the Plan and the administration thereof and to make those records available at all reasonable times for inspection and audit by the Arizona Auditor General or the Board during the terms of this agreement and for five years after its completion or termination. The records will be delivered to the Board office or another location designated by the Board with reasonable notice to the parties providing such records.

15.5 Code Compliance

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

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

15.6 No Guarantee of Tax Consequences

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

15.7 Indemnification of Employer

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

15.8 Non-Assignability of Rights

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

15.9 Headings

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

15.10 Plan Provisions Controlling

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

15.11 Severability

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

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

ARIZONA BOARD OF REGENTS

By Joel Sideman
Joel Sideman, Executive Director

Appendix A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Article XI. Miscellaneous Laws

11.1 Michelle's Law

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

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

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

11.2 Mental Health Party and Addiction Equity Act of 2008

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

11.3 Genetic Information Nondiscrimination Act of 2008

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

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

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

DATED this 23 day of SEPTEMBER, 2010.

ARIZONA BOARD OF REGENTS

By: _____
Thomas K. Anderes
President

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**3.1 Eligibility to Participate**

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

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

"3.3 Participation Following Termination of Employment or Loss of Eligibility

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

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

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

DATED this 1 day of DECEMBER, 2011.

ARIZONA BOARD OF REGENTS

By: _____

Title: PRESIDENT

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

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

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

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

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

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

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

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

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

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

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

DATED this 10 day of DECEMBER, 2012.

ARIZONA BOARD OF REGENTS

By: _____

Title: PRESIDENT

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

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

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

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

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

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

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

"**3.1 Eligibility to Participate**

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

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

"**3.3 Participation Following Termination of Employment or Loss of Eligibility**

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

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

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

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

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

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

- No more than $500.00 of the Participant's unused Health FSA Account may be carried over for use in the next Plan Year.

- Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum annual benefit amount that a Participant may elect to receive under this Plan, as provided in Section 7.4(b), in the form of reimbursements for Medical Care Expenses incurred during the Plan Year to which the amounts were carried forward.

- Medical Care Expenses incurred in the current Plan Year will be reimbursed first from the amounts available for such reimbursement for that Plan Year. Following the close of the

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

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

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

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

"**7.8 Reimbursements From Health FSA After Termination of Participation; COBRA**

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

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

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

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

DATED this 22 day of June, 2015.

ARIZONA BOARD OF REGENTS

By: _____
Title: President

REQUEST FOR PROPOSAL

ARIZONA BOARD OF REGENTS
REQUEST FOR PROFESSIONAL SERVICES
TO PROVIDE ADMINISTRATION OF THE
FLEXIBLE SPENDING ACCOUNT PROGRAM AND
BENEFITS BILLING AND COLLECTION FOR THE ARIZONA UNIVERSITY SYSTEM
RFP 2020004

AMENDMENT 1

The following questions have been submitted to ABOR in response to RFP 2020004 for a Third-Party Administrator submitted.

1. Why has ABOR decided to bid these services at this time (fees, service issues, standard due diligence, etc.)?
    a. Are there service level concerns with the current administrator?
    b. If no service issues, what would be the catalyst for ABOR to change administrators?

Procurement policy requires the Arizona Board of Regents to competitively bid these services every five years.

2. How long has the current administrator provided services to the ABOR?

20 years

3. Is ABOR satisfied with the level of FSA/ tax advantaged benefit account participation?

UA - Yes, we are satisfied.
NAU - We would like to see increased enrollment for employees not enrolled in an HDHP.
ASU- Yes, we are satisfied.

4. What is the current administrative fee for the benefits which the State is seeking (i.e. FSA, DCAP, Benefit Billing)? Does the ABOR cover the cost of these benefits or do participants pay the fee?

$3.00 for participants in one or two benefit pools. This fee is paid by ABOR/universities.

5. Does ABOR work with a benefits consultant or broker? If so, who (name, company).

No

6. Who is your benefit administration platform provider and payroll vendor? Does the ABOR anticipate any changes to these platforms or replacement of current systems?

Arizona State University, Northern Arizona University and The University of Arizona each use PeopleSoft. Each university is on a separate system, running independent of each other. The Board office uses the Arizona State University payroll system.

7. Can the ABOR provide an overview of the key organizational and benefit account priorities in 2021 and 2022, as well as, long term strategies to attract and retain key talent in an increasingly competitive labor market?

The universities offer a rich benefit package that is an important part of our total reward strategy. The university system is focused on maintaining broad coverage and flexibility for the lowest cost. Currently due to the COVID -19 pandemic many positions are in hiring freeze.

8. Are any communication/marketing materials being mailed directly to participant homes? If so, what is the quantity? Is this collateral being mailed to all eligible employees or current participants?

Material is only available electronically

9. Is there any requirement for marketing material to be mailed? What was the quantity and number of locations for the most recent plan year? Can material be emailed or otherwise posted on the website?

Material is only available electronically

10. What is the expectation / projections for increased participation? Has enrollment been relatively flat the past two plan years?

Given the current conditions, we are unsure how to project for future. Employees are making changes due to the COVID -19 pandemic. Participation at the University of Arizona has been consistent in the past two years, while enrollment at Northern Arizona University has decreased as more employees have enrolled in the HDHP/HAS plan.

11. What was the forfeiture information such as;
a) The total number of participants who forfeited money in the last plan year for health care FSAs?
b) The total amount of forfeited money for the last plan year for health care FSAs?
c) The total number of participants who forfeited money in the last plan year for Dependent Care FSAs?
d) The total amount of forfeited money for the last plan year for dependent care FSAs?

The university system does not have the information readily available.

12. What amenities or service features do you like the most about the current FSA, Benefit Billing plan administrator?

Current administrator is always very responsive to both customer and HR inquiries. They work with the universities to resolve discrepancies and are focused on doing right by the customer/our employees. The employer portal to view member claim/contribution amounts as well as uploading/downloading reports is very helpful. Benefits billing and COBRA services are also good features.

Our current vendor provides timely updates involving federal law changes to the administrators and then to the participants.

13. Does the ABOR have new technological objectives for administration of these services?

The discrepancy report which identifies people on unpaid leave of absence must be manually reconciled a every pay period. If an automated process can be developed, it would save a lot of time.

14. Are there particular features or processes the ABOR is seeking in the chosen vendor?

A user friendly website, user app for filing claims. Additional automated processed (see #13 above). Benefits billing and COBRA notification services. An administrative portal with security at a university level.

15. Will the incumbent TPA handle the claims run-out administration for the final plan year of the contract?

Yes

16. What is the current administrator's claims processing turnaround time for FSA and DCAP services?

One business day

17. Approximately what percentage of your employee base has access to email?

90%

18. How important is it to for the ABOR to have a solution that offers a single debit card for all the account with an online portal and mobile app that provides full account functionality for participants?

This is very important

19. Does the current service provider provide claims integration?

This service is provided at the university level

20. Can the ABOR provide information regarding any service provider expectations involved with annual open enrollment meetings, including the format ABOR might utilize as part of this process? How many days and locations will the new service provider be expected to attend?

UA - If we hold an in person expo, we would want the vendor to be available for two days.

NAU - Most likely hold a virtual meeting.

ASU – A one day in person expo or possibly virtual presentation. Possibly a financial fair in the following year

21. Will the ABOR provide the current performance guarantees established with the current provider?

Currently have no service guarantees

22. Has the current administrator paid penalties for failing to meet performance guaranteed? Is so, where did they call short?

23. Can ABOR confirm the annual quantity of printed materials needed for FSA, COBRA, as well as, the annual OE meetings with HR across the State?

3300

24. Can the ABOR confirm there is no restriction in allowing dependent care participants to utilize the provided debit card for both qualified healthcare and dependent care expense?

There is no restriction

25. In assessing a new partner to provide the FSA, Benefit Billing services to ABOR, can you please rate on a scale of 1-10, the importance of the following in a new partner;
a) Single, integrated solution to deliver all accounts with a single card to access all benefit dollars? 10
b) Enhanced features/functionality that is not available with your current solution? 8
c) Client portal to manage enrollment, transactions, funding, etc. 10
d) Mobile and Online application that links all accounts and shows a dashboard of accounts, balances, transactions, etc. 10

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RFP 2020004

AMENDMENT 2

The following questions have been submitted to ABOR in response to RFP 2020004 for a Third-Party Administrator submitted.

1. On average, how many individuals do you anticipate will be on the billing and collection service per month for each location of ABOR, ASU and for UA?

   Currently only NAU is using this service. However, it will be available to ABOR, ASU and UA if they choose to use it.

2. What is the expectation of NAU for increased FSA participation? Is there a percentage over and above 19% they are looking for?

   NAU does not have a specific percentage they are targeting because it depends on the number of employees enrolled in the HSA. They are only looking to increase enrollment for the non-HSA plan employees.

3. Section E.6.1 indicates that a pricing form is attached as Exhibit C. Section P is labeled as "Attachment C – Fees for Services" but most of the page is blank. Is there a missing Exhibit C that indicates the recommended format for the pricing schedule?

   Formatting for this section is up to the offeror.

4. Section E.3 requires three references but also makes a reference to "companies terminating your services." Is there a requirement for terminated references?

   ABOR requests at least three references identifying clients with requirements similar to those of ABOR, preferably located in Arizona. These references must be administered by the same office you intend to use for the services requested in this RFP. Provide the company name, contact person, address, email, telephone number and the number of employees covered by the services provided.

   In addition, ABOR requests Offeror to provide a list of companies terminating service over the past three years. This list should include company, contact name, telephone number, and date of termination.

REQUEST FOR PROPOSAL

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AMENDMENT 3

The following questions have been submitted to ABOR in response to RFP 2020004 for a Third-Party Administrator submitted.

1. **Page 10 Section C, Item # 14.** indicates the Offeror may submit requests for changes or additions to ABOR terms and conditions, but an Offer shouldn't be contingent upon such changes or additions. And Item # 16 indicates the successful Offeror(s) "**will"** be expected to enter into a Contract with ABOR. ABOR's terms and conditions "**shall"** be incorporated into the resulting Contract between ABOR and the successful Offeror. **QUESTION:** If the successful Offeror's requested changes or additions are rejected by ABOR, may such Offeror withdraw their proposal, or will the successful Offer be required to move forward and enter into the Contract that includes all of ABOR's terms and conditions?

   While ABOR prefers to use all of its terms and conditions, it is possible that some may be negotiable according to applicable law. Until a contract is signed by both parties, either party may withdraw their proposal, subject to applicable law.

2. **Page 11 Section C, Item 17.** Indicates if subcontracting is necessary, the Offeror shall make every effort to use SB & SDB in the performance of the Contract. **QUESTION:** Does the current contract include any commitments for SB or SDB? Are there any specific goals? Please explain what you mean by make every effort. How will the Offeror be required to show that it made "every effort?"

   The current contract includes a commitment for SB & SDB. ABOR means that Offeror will use SB or SDB, unless it becomes legally impracticable or impossible.

3. **Page 15 Section E, Item 2.5.** indicates the Offeror will be required to conduct relevant and appropriate fingerprinting according to ABOR polices. **QUESTION:** Can you tell us what those policies are and whether or not you anticipate that fingerprinting will be necessary as part of this contract? Will you accept Offeror's indication of ***PASS RESULTS*** using Offeror's own mandatory background checks in place of physical fingerprinting?

   ABOR's policy requires fingerprints for safety sensitive position. See ABOR Policy 6-709.

4. **Page 15 Section E, Item 2.6.** indicates the Offeror may subcontract installation, training, warranty, or maintenance service with prior ABOR authorization. **QUESTION:** Is this an exhaustive list or may the Offeror subcontract other aspects of the services as well?

   It is not exhaustive, provided subcontractors otherwise comply with the other terms in the contract.

5. **Page 15 Section E, Item 2.7.** ABOR may request a tour of any administrative or service facilities intended to provide benefits stated in the proposal. No fees will be paid b ABOR for such a tour and/or demonstration **QUESTION:** Will Offeror will be expected to cover the travel-related costs for any tours at administrative or service facilities located outside of

Phoenix, AZ – for example, at service sites located in other states? If yes; how many ABOR representatives are expected to tour administrative/service facilities?

No, ABOR would cover the travel cost.

6. **Page 17 Section E, Item 4.3.4.** Provide a representative to attend open enrollment meetings. **QUESTION:** On average, how many OE meetings/days annually? How many different locations or campuses? Are these meetings held on successive workdays?

   UA - If we hold an in-person expo, we would want the vendor to be available for two days.
   NAU - Most likely hold a virtual meeting.
   ASU – A one day in person expo or possibly virtual presentation. Possibly a financial fair in the following year.

   The meetings may not be held on successive days.

7. **Page 18 Section E, Item 4.4.4.** Enrollment procedures will be completed annually or upon eligibility by all eligible employees who wish to redirect salary to a flexible spending account for the purposes of dependent care expense reimbursement and/or health care expense reimbursement. Describe your ability to provide these services electronically. **QUESTION:** Are you asking if the Offeror will provide an online enrollment solution for both OE and ongoing new hire enrollment for the employee to make their election for an FSA? What method are employees using today to enroll in the FSA program? Are they using the current administrator's system to enroll in FSA or the ABOR online benefits enrollment system?

   Employees us the university's benefit enrollment system. Universities do not have a paper-based system.

8. **Page 19 Section E, Item 4.4.24.** Upon enrollment the Offeror shall notify all participants of their COBRA options available upon separation. **QUESTION:** Is this RFP soliciting COBRA administration for all benefit plans, including the ABOR group health, dental and/or vision plans? Or is this a reference to Healthcare FSA only?

   COBRA services will only be for the FSA plan

9. **Page 19 Section E, Item 4.6.4.** Methods of payment shall include: Debit Card and Credit Card. **QUESTION:** While our company will support payment by Debit/Credit Card – this is not a preferred method to use as a result of fees associated with such transactions. Will the Offeror's proposal be eliminated from consideration if we do not agree to include these payment options?

   No, however this is a benefit our participants currently use.