

SAINT MARY'S COLLEGE OF CALIFORNIA SELF-FUNDED HEALTH REIMBURSEMENT PLAN

Summary Plan Description

**Originally Effective as of January 1, 2023
Amended and Restated as of January 1, 2027**

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PLAN INFORMATION

This document, when incorporated with the plan document, benefit booklets and certificates, and provider contracts, policies, and descriptions related to this Plan and the Blue Shield of California PPO group medical plan and Kaiser group medical plan, referred to herein as the “Applicable Health Plan,” collectively the “Benefit Documents,” constitutes this Plan’s Summary Plan Description, or “SPD,” pursuant to the Employee Retirement Income Security Act of 1974, as amended, or “ERISA.” This is not the official Plan Document.

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan’s benefits as of January 1, 2027, which may change from time to time. The Plan Year is January 1 through December 31 of the same calendar year. HRA funding and the maximum annual reimbursement amount are administered on the same calendar-year basis. You should keep this SPD with the Benefit Documents provided to you upon enrollment in the Plan.

Plan Name:	Saint Mary's College of California Self-Funded Health Reimbursement Plan
Type of Plan:	Welfare Benefit Plan
Type of Administration:	Employer administered, with claims administration delegated to Marin Benefits Administrators
Plan Year:	The Plan Year is January 1 through December 31 of the same calendar year
ERISA Plan Number:	502
Effective Date of this SPD:	January 1, 2027
Original Effective Date of Plan:	January 1, 2023
Funding Method:	Self-Insured
Source of Contributions:	From general assets of Saint Mary's College of California
Plan Sponsor and Plan Administrator:	Saint Mary's College of California 1928 Saint Marys Road Moraga, CA 94575 (925) 631-4055
Plan Sponsor’s Employer Identification Number:	94-1156599
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrator:	Marin Benefits, Inc. d/b/a Marin Benefits Administrators 6366 Commerce Blvd., Suite 293 Rohnert Park, CA 94928 (415) 526-1401 www.marinbenefits.com

INTRODUCTION

Establishment, Purpose, and Definitions

Plan Sponsor maintains the Plan for the exclusive benefit of, and to provide welfare benefits to, its eligible employees and their eligible Spouses and Dependents. The Plan is a Health Reimbursement Arrangement Plan that is integrated with the Applicable Health Plan. It is intended that the Plan meet the requirements for qualification under Code §105.

The Plan is provided at no cost to you. The purpose of the Plan is to reimburse you, up to certain limits, for your own and your Spouse's and Dependent(s)' Medical Care Expenses on a nontaxable basis from a health reimbursement account. Reimbursements for Medical Care Expenses paid by the Plan generally are excludable from your taxable income. Note, however, that you may be required to contribute toward your and your Spouse's and Dependent(s)' coverage under the Applicable Health Plan.

It is intended that the terms of this Plan are legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees and their covered Dependents.

This SPD describes the basic features of the Plan and how it operates. It is only a summary of the key parts of the official Plan Document and a brief description of your rights as a Participant in the Plan. This SPD is not intended to give any substantive rights to benefits that are not already provided for in the official Plan Document and the Benefit Documents. Accordingly, if the terms of this SPD conflict with the terms of the official Plan Document, the terms of the official Plan Document will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this SPD with respect to the legal compliance requirements of ERISA and any other federal law, this SPD will control, unless superseded by applicable law.

For purposes of this SPD, the following definitions apply:

Applicable Health Plan means the Blue Shield of California PPO group medical plan; Kaiser group medical plan sponsored by the Employer in which the Participant is enrolled.

Benefits means the reimbursement benefits for Medical Care Expenses as described in this SPD.

Claims Administrator means Marin Benefits, Inc. d/b/a Marin Benefits Administrators.

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

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

Dependent has the meaning set forth in Appendix A.

Employee means a common-law employee of the Employer who is eligible for and enrolled in the Applicable Health Plan, as determined under the Employer's eligibility rules.

Employer means Saint Mary's College of California.

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

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

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

HRA or HRA Account means a health reimbursement arrangement account as described in this SPD.

Medical Care Expenses has the meaning defined in Appendix B.

Participant means an individual who is an Eligible Employee and who is participating in this Plan in accordance with the eligibility and participation rules listed in this Plan and in Appendix A.

Plan means the Saint Mary's College of California Self-Funded Health Reimbursement Plan.

Plan Administrator means Saint Mary's College of California.

Plan Sponsor means Saint Mary's College of California.

Plan Year means January 1 through December 31 of the same calendar year.

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

Spouse has the meaning defined in Appendix A.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Eligibility Rules

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

HRA Participation

If you become a Participant, the Plan will maintain an HRA in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Plan Sponsor), and it does not bear interest or accrue earnings of any kind. Medical Care Expenses must generally be submitted to the Applicable Health Plan in accordance with its claims procedures before reimbursement is available under this Plan, and an Explanation of Benefits (EOB) is generally required to substantiate that the expense is covered under the Applicable Health Plan and to prevent duplicate reimbursement. Benefit card transactions may be paid at the point of service, but remain subject to substantiation, post-payment review, and recovery if the expense is not eligible under the Plan.

If your participation in the Plan has ceased due to cessation of employment with Employer and you later return to employment, you must meet the Plan's then current re-entry guidelines for participation in the Plan.

Enrollment and Elections

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

Annual Open Enrollment. You may change your Applicable Health Plan election, or enroll in the Applicable Health Plan if you did not enroll when first eligible, during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the

subsequent Plan Year depending on the policies adopted by the Plan Sponsor.

If you first become covered under the Applicable Health Plan after the beginning of a Plan Year, your HRA Account will be credited with the applicable Plan Year amount as of your HRA participation date, unless otherwise stated in Appendix B or determined by the Plan Administrator on a uniform and consistent basis. That amount is available only for eligible Medical Care Expenses incurred on or after your HRA participation date and during the applicable Plan Year. Medical Care Expenses incurred before your HRA participation date are not eligible for reimbursement under this Plan.

Special Enrollment. You may change your elections regarding the Applicable Health Plan if you have a special enrollment right and you timely notify Plan Administrator. Please refer to the Plan Document and Benefit Documents for the Applicable Health Plan to understand your special enrollment rights under the Applicable Health Plan.

Waiver of Participation. If you participate in the Plan, you may be ineligible to make Health Savings Account ("HSA") contributions. To remove the Plan as an obstacle to HSA contributions, you may elect to waive or suspend HRA coverage for a future Plan Year by submitting a Waiver of Participation Form to the Plan Administrator before the beginning of that Plan Year. Your waiver will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year, except as otherwise required by applicable law.

If you waive or suspend HRA coverage for a Plan Year, you will not receive reimbursements for Medical Care Expenses incurred during the Plan Year to which the waiver applies, except to the extent an expense is otherwise eligible under the Plan and the Plan Administrator determines that reimbursement is permitted without disqualifying the Participant from HSA eligibility under Code §223 and applicable guidance.

The Employer will suspend contributions to your HRA Account for the waived or suspended Plan Year. Medical Care Expenses incurred before the waiver or suspension takes effect may be reimbursed during the waived or suspended Plan Year, subject to the Plan's reimbursement procedures and applicable claims submission deadlines, so long as no waiver or suspension was in effect on the date the expenses were incurred.

In lieu of a temporary waiver or suspension of your Plan participation, you may elect to permanently opt out of and waive future reimbursements from your HRA. If you make that election, you will not receive reimbursements for any Medical Care Expenses incurred after the opt-out election takes effect. Medical Care Expenses incurred before the opt-out election takes effect, however, may be reimbursed after the opt-out election takes effect, subject to the Plan's reimbursement procedures and applicable claims submission deadlines, so long as no waiver, suspension, or opt-out election was in effect on the date the expenses were incurred. If you permanently opt out of this Plan, the Plan Administrator will also discontinue contributions to your HRA Account for the portion of the applicable Plan Year beginning on the date the opt-out election takes effect and for each Plan Year thereafter, unless you are permitted to revoke the opt-out election in accordance with procedures established by the Plan Administrator and applicable law.

Dependent Coverage under QMCSOs

The Plan may be required to cover your child or children due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child in the Plan. You may obtain a copy of the Plan Administrator's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

A QMCSO, as defined in ERISA §609(a), is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a Participant or beneficiary is eligible under the Plan, and that Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Continuation of Coverage Rights

COBRA is a federal law that gives certain Employees, Spouses, and Dependents the right to temporary continuation of health care coverage. See the "Continuation of Coverage Rights" section of this SPD for additional details on a Participant's, Spouse's or Dependent's right to continue benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

HRA BENEFITS AND ESTABLISHMENT OF ACCOUNTS

Benefits

Please refer to Appendix B of this SPD for details regarding the Plan's Benefits, including the allowable benefit maximum available to you for the Plan Year. Participants receive Benefits in the form of reimbursements of Medical Care Expenses. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Before the start of each Plan Year, the Plan Administrator will determine the maximum annual amount that may be credited during that Plan Year to your HRA. Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses incurred by you, your Spouse, or your Dependents. Note that your Spouse and Dependents also must be enrolled in the Applicable Health Plan in order to be eligible for Benefits under this Plan.

Establishment of HRA Accounts

Once you become a Participant, the Plan will maintain an HRA Account in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account – it is not funded (all reimbursements are paid from the general assets of Employer), and it does not bear interest or accrue earnings of any kind. Medical Care Expenses must generally be submitted to the Applicable Health Plan in accordance with its claims procedures before reimbursement is available under this Plan, and an Explanation of Benefits (EOB) is generally required to substantiate that the expense is covered under the Applicable Health Plan and to prevent duplicate reimbursement. Benefit card transactions may be paid at the point of service, but remain subject to substantiation, post-payment review, and recovery if the expense is not eligible under the Plan.

The annual HRA amount available to you is determined on a Plan Year basis, as described in Appendix B. If you are eligible and participating in the Plan on January 1, your HRA Account will be credited with the applicable Plan Year amount as of January 1. If you first become eligible for and begin participating in the Plan after January 1, including because your coverage begins

during annual open enrollment, your HRA Account will be credited with the full applicable Plan Year amount as of your HRA participation date, unless the Plan Administrator determines otherwise on a uniform and consistent basis. That amount is available only for eligible Medical Care Expenses incurred on or after your HRA participation date and during the applicable Plan Year.

Debiting HRA Accounts

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

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

Reimbursement After Termination

When a Participant ceases to be a Participant in the Plan, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the Participant's participation terminates, except to the extent the Participant is entitled to continuation of coverage rights under COBRA or applicable law. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the period of coverage prior to termination of participation, provided that the Participant files a claim within ninety (90) days following the date the Participant's participation in the Plan terminates.

Recovery of Overpayment

You must immediately repay any excess or improper payments or reimbursements paid to you, your Spouse or your Dependents by the Plan in error. The Plan may recover amounts paid in error by requiring repayment, offsetting future reimbursements, suspending or deactivating benefit card access, and/or using other lawful collection methods, consistent with applicable law.

Coverage During Leaves of Absence

You may be eligible to continue Benefits under the Plan for a period of time during a leave of absence, subject to the leave policies and procedures adopted by the Employer and to the extent prescribed by law. If the Employer is subject to the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's

Benefits on the same terms and conditions as if the Participant were still an active Employee eligible to participate in the Plan. The Employer shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law. For more information on coverage during leaves of absence, please refer to the Benefit Documents for the Applicable Health Plan or contact the Employer.

CONTINUATION OF COVERAGE RIGHTS

This Plan is a group health plan that is integrated with the Applicable Health Plan. COBRA continuation coverage may be available under this Plan to the extent required by federal COBRA or other applicable law. Because this HRA is integrated with the Applicable Health Plan, continuation coverage under the HRA may be conditioned on continued coverage under the Applicable Health Plan, to the extent permitted by applicable law and the Plan Administrator's COBRA administration procedures. Please refer to the Benefit Documents for the Applicable Health Plan and any COBRA election materials for additional continuation coverage information.

Introduction

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

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

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact the Plan Administrator.

Other Coverage Options

Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period.

Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at www.healthcare.gov.

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

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

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

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

Qualifying Events for COBRA Coverage

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

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

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

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

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

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

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

Notifying the Plan of a Qualifying Event

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

You Must Notify the Plan Administrator of Certain Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and Spouse or a Dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan

Administrator in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, Spouse or Dependent who underwent the qualifying event. You must provide this notice to:

Saint Mary's College of California
Attention: Human Resources
1928 Saint Marys Road
Moraga, CA 94575
(925) 631-4055

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

COBRA Coverage Elections

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

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

Length of COBRA Coverage

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

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

- 18 months of coverage, due to termination of employment or a reduction in hours; or
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is

determined to be disabled by the Social Security Administration before the 60th day of COBRA Coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

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

Dependent/Qualified Beneficiary Coverage.

Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

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

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

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

Saint Mary's College of California
Attention: Human Resources
1928 Saint Marys Road
Moraga, CA 94575
(925) 631-4055

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

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

Early Termination of COBRA Coverage

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

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that you must notify the Plan Administrator in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. Note that you must notify the Plan Administrator in writing within 30 days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;
- The Employer ceases to provide any COBRA-eligible group health plan coverage for its employees; or
- For any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA

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

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

After you make your first payment for COBRA Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA Coverage is due

on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates.**

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

Plan Contact Information

In order to protect your and your Spouse's and Dependent's rights, you should keep the Employer and Plan Administrator informed of any changes in your address and the addresses of family members.

Saint Mary's College of California Self-Funded Health
Reimbursement Plan
1928 Saint Marys Road
Moraga, CA 94575
(925) 631-4055

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions may generally apply to the Applicable Health Plan associated with your HRA: Newborns' and Mothers' Health Protection Act of 1996, Women's Health and Cancer Rights Act of 1998, Affordable Care Act, Mental Health Parity and Addiction Equity, the Genetic Information Nondiscrimination Act of 2008, and the Consolidated Appropriations Act of 2021. For more information regarding your rights under these laws, please refer to the Benefit Documents for the Applicable Health Plan.

Federal nondiscrimination laws, including Title VII of the Civil Rights Act of 1964, may also apply to the Employer's provision of health benefits.

Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures apply to reimbursement requests under this Health Reimbursement Arrangement (“HRA”) Plan. Claims and appeals for benefits under the Applicable Health Plan are governed by the Applicable Health Plan’s plan documents. These HRA claims and appeal procedures shall be construed and applied in a manner intended to comply with ERISA and the Department of Labor claims procedure regulation at 29 C.F.R. § 2560.503-1, as applicable.

HRA Reimbursements

Marin Benefits, Inc. d/b/a Marin Benefits Administrators is the Claims Administrator for initial claims determinations and will process reimbursement requests and benefit card transactions under procedures established for the Plan. The Plan Administrator (Saint Mary's College of California) is the Plan fiduciary with discretionary authority to interpret Plan terms and decide appeals, unless the Plan Administrator delegates appeal authority in writing. If the Claims Administrator denies your claim in whole or in part, you will receive written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal for a review of the denied claim in accordance with the Plan’s claims and appeal procedures.

Reimbursements under the Plan must be submitted pursuant to procedures established by the Claims Administrator (see Appendix B for additional details). No reimbursement will be made for any Medical Care Expense incurred during a period in which you, your Spouse, or your Dependent for whom the expense was incurred are not enrolled in the Applicable Health Plan, except as required by COBRA or other applicable law.

A statement from a medical practitioner, including a Letter of Medical Necessity, may be required to substantiate certain expenses. However, a Letter of Medical Necessity does not, by itself, make an expense eligible for reimbursement if the expense is otherwise excluded under the Plan or is not a service or item covered, or that would be covered if submitted, under the Applicable Health Plan. This Plan may exclude expenses even if they otherwise meet the definition of “medical care” under Code §213(d).

Benefit Card Payments. The Claims Administrator will provide Participants with a benefit card linked to the HRA to pay certain eligible expenses at the point of service, subject to the Claims Administrator’s card procedures. You must comply with the card substantiation procedures by providing any requested documentation that supports the reimbursement. Failure to timely substantiate a benefit card transaction, use of the benefit card for an ineligible expense, or receipt of a refund or reimbursement from another source for an expense paid by the Plan may result in the amount being treated as an overpayment subject to repayment under the Plan. Approval of a benefit card transaction at the point of sale does not guarantee that the expense is eligible under the Plan; all benefit card transactions remain subject to post-payment review.

Benefit Card Suspension. The Claims Administrator may suspend or deactivate a benefit card if substantiation is not provided upon request, if an expense is determined to be ineligible, or if continued card use would violate Plan terms or applicable law.

In general, a Plan Participant may apply for reimbursement by submitting a request to the Claims Administrator in such form as the Claims Administrator may prescribe, subject to the following deadlines: active Participants must submit claims no later than March 31 following the end of the Plan Year in which the Medical Care Expense was incurred, and terminated Participants must submit claims within ninety (90) days following the date the Participant’s participation in the Plan terminates. At minimum, the request for reimbursement must include:

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

documentation that a medicine or drug was prescribed, or a more detailed certification from the Claimant).

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

Requests for reimbursement should be sent to:

Marin Benefits, Inc. d/b/a Marin Benefits
Administrators
6366 Commerce Blvd., Suite 293
Rohnert Park, CA 94928
Online claim submission: www.marinbenefits.com

HRA Claims Procedures

Within 30 days after receipt by the Claims Administrator of a reimbursement request from you or another claimant ("Claimant"), the Claims Administrator will either reimburse the Claimant for the Medical Care Expenses, if the claim is approved, or notify the Claimant that the claim has been denied in whole or in part. This time period may be extended by an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Claimant 45 days in which to complete the previously incomplete reimbursement claim.

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

- The specific reason for the Adverse Determination;
- References to the specific Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the applicable time limits;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access

to, and copies of, all documents, records, and other information relevant to the claim;

- If applicable, specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. Such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) after an appeal.

HRA Claims Appeals Procedures

If the Claimant disagrees with an Adverse Determination, the Claimant or the Claimant's appointed representative may formally request an appeal by following the Plan Administrator's appeal procedures. The Claimant may appeal any Adverse Determination within 180 days of receipt of such denial by submitting a written request for review to the Plan Administrator. If the Claimant does not appeal in a timely manner, the Claimant may lose the right to later object to the Adverse Determination or to file suit with respect to the claim.

If the claim on appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a written notification of the Plan's appeal decision ("Appeal Decision") within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan. Any determination by the Plan Administrator or any authorized delegate will be final and binding to the fullest extent permitted by law, subject to the Claimant's rights under ERISA. The notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Plan provisions on which the Appeal Decision is based;
- A statement regarding the Claimant's right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Plan and the Claimant's right to obtain information about such procedures;
- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the

Appeal Decision is based. Such specific references may be made available to the Claimant by including a statement that the information is available free of charge upon the Claimant's request; and

- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a).

Voluntary Second-Level Appeal, If Available. The Plan is not required to provide a second-level appeal unless the Plan Administrator adopts written procedures making such an appeal available. If a voluntary second-level appeal is made available, the Claimant must file the second-level appeal within the time period and in the manner described in the written procedures provided by the Plan Administrator. The availability of a voluntary second-level appeal shall not shorten or otherwise limit any rights the Claimant may have under ERISA following completion of the required appeal procedure.

Full and Fair Review. The review of the claim shall take into account all comments, documents, records, and other information the Claimant submits, without regard to whether such information was submitted or considered in the initial Adverse Determination. The Plan will identify, upon request to the Plan Administrator, any medical experts or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination. The review of the appeal shall be conducted by the Plan Administrator or an authorized delegate who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.

External Review. To the extent any adverse benefit determination under this Plan involves a medical judgment or is otherwise eligible for external review under 29 C.F.R. § 2590.715-2719, you may be entitled to request external review after exhausting the Plan's internal appeal. Because this Plan is integrated with the Applicable Health Plan, medical-necessity and coverage determinations are made under the Applicable Health Plan, and any external review of such determinations will be conducted under the Applicable Health Plan's claims and external review procedures. Determinations

under this Plan that involve only eligibility, substantiation, or the amount available for reimbursement are not subject to external review.

Language Access. If notices under this Plan are sent to an address in a county where ten percent (10%) or more of the population is literate only in the same non-English language, the Plan will provide, upon request, oral language assistance and a written notice in that language describing how to access the Plan's claims and appeal procedures.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust the Plan's claims and appeal procedures before filing a lawsuit for benefits. However, if the Plan fails to establish or follow claims procedures consistent with applicable ERISA requirements, you may be deemed to have exhausted the administrative remedies available under the Plan and may be permitted to pursue any available remedies under ERISA Section 502(a), subject to applicable law.

Notwithstanding the foregoing, administrative remedies will not be deemed exhausted based on a Plan failure that is de minimis, non-prejudicial, attributable to good cause or matters beyond the Plan's control, occurs in the context of an ongoing good-faith exchange of information, and does not reflect a pattern or practice of noncompliance. You may request a written explanation from the Plan of any alleged violation, and the Plan will provide such explanation within the time required by applicable law.

Exhausting Administrative Remedies and Filing Suit

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

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

PLAN ADMINISTRATION

In General

The Plan Administrator of the Plan is the “Named Fiduciary” within the meaning of such terms under ERISA, who shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator is the Plan's agent for service of legal process.

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

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

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

Plan Administrator will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to

receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Privacy and Security of Information

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

Plan Amendment and Termination

Plan Sponsor reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of any balance in the HRA Account under this Plan. Any amendment, termination or other action by Plan Administrator will be done in accordance with Plan Administrator’s normal operating procedures.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

The Affordable Care Act generally prohibits group health plans and health insurance issuers from imposing preexisting condition exclusions. If you have questions about how the Applicable Health Plan covers preexisting conditions, contact the Plan Administrator or refer to the Applicable Health Plan Benefit Documents.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone

numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

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

OTHER IMPORTANT INFORMATION

Legal Actions

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

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

- Before bringing any lawsuit seeking benefits under the Plan, you must complete the applicable claims procedure set out in the Plan, as applicable, and comply with all applicable deadlines. If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.
- You must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary

duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Non-Assignment of Benefits

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

Controlling Documents

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

APPENDIX A

SAINT MARY'S COLLEGE OF CALIFORNIA SELF-FUNDED HEALTH REIMBURSEMENT PLAN SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Eligibility

A common-law employee of the Employer who is eligible for and enrolled in the Applicable Health Plan, as determined under the Employer's eligibility rules. The Plan Administrator shall determine the employee's eligibility or ineligibility for the Applicable Health Plan based on the eligibility rules documented and described under the Applicable Health Plan.

Waiting Period. You are eligible to participate in the Plan upon fulfilling the waiting period of the Applicable Health Plan.

Effective Date of Coverage. You will commence participation in the Plan on the date you enroll in the Applicable Health Plan.

Dependent Eligibility

Unless specified otherwise under the Applicable Health Plan Benefit Documents, coverage for Spouses or Dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage).

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

- Your Spouse, as defined in the Applicable Health Plan, which is the legal Spouse as defined under the Code or Domestic Partner of an Eligible Employee. Notwithstanding the foregoing, reimbursements under the HRA are intended to be excludable from income only to the extent permitted under the Code. To the extent a Domestic Partner or the child of a Domestic Partner is not the Participant's spouse or tax dependent for federal tax purposes, reimbursements for that individual may be taxable or may be limited, as determined by the Plan Administrator in accordance with applicable law.
- Your child or children under age 26, regardless of financial dependency, residency with you, marital status, or student status, or, if older, your unmarried child who is principally supported by you and who is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred before age 26. For purposes of the Plan, a child includes a natural child, stepchild, legally adopted child, child placed with you for adoption, eligible foster child, or a child for whom you have court-appointed legal guardianship, to the extent the child is eligible under the Applicable Health Plan.
- An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

Cessation of Participation

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

If you cease to be an eligible employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described in this SPD. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the HRA, provided that you comply with the reimbursement request procedures required under the Plan. Any unused portions will not be available after termination of employment. A former Participant whose participation has ceased due to cessation of employment and who returns to employment must meet the Plan Administrator's then-current re-entry guidelines for participation in the Plan.

If your participation terminates, you may receive reimbursement for Medical Care Expenses incurred prior to your termination of participation if you apply for reimbursement within ninety (90) days following the date your participation in the Plan terminates, in accordance with the claims procedures described in this SPD.

Changes in Family Status

If you change your Applicable Health Plan election from single to family coverage during the Plan Year, any increase in the maximum annual HRA amount (if applicable) will be applied based on the effective date the family coverage begins, in accordance with Plan Administrator procedures. If you change your Applicable Health Plan election from family to single coverage during the Plan Year, any decrease in the maximum annual HRA amount (if applicable) will be applied as of the effective date of the change. If a Participant has already been reimbursed up to the applicable maximum available prior to the change, additional reimbursements may be limited for the remainder of the Plan Year.

APPENDIX B

SAINT MARY'S COLLEGE OF CALIFORNIA SELF-FUNDED HEALTH REIMBURSEMENT PLAN SUMMARY PLAN DESCRIPTION

Schedule of Benefits

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

Health Reimbursement Coverage

- **Benefits Provided.** The Plan provides reimbursement to participants for certain Medical Care Expenses that are incurred during the Plan Year and not otherwise reimbursed under the Applicable Health Plan or another health plan.
- **Medical Care Expenses.** Reimbursable Medical Care Expenses are expenses for medical care within the meaning of Code §213(d), but only to the extent such expenses are covered under the Applicable Health Plan, satisfy the requirements of this Appendix B, and are not excluded under the Plan.
- **Covered Expenses.** Eligible expenses are limited to services covered by the Participant's Applicable Health Plan. For Blue Shield PPO: Eligible expenses are limited to medical services and prescription drug expenses covered by the Participant's Blue Shield of California PPO group medical plan, including eligible services received in-network or out-of-network. For Kaiser: Eligible expenses are limited to medical services covered by the Participant's Kaiser group medical plan. Prescription drugs must be filled through a Kaiser network pharmacy or approved by Kaiser to be eligible for HRA reimbursement.
- **Excluded Expenses.** For Blue Shield PPO: The HRA does not reimburse services or items not covered under the Applicable Health Plan, including dental services, vision/optical services, and over-the-counter medications, vitamins, and similar items, even with a prescription, unless otherwise required by law. For Kaiser: The HRA does not reimburse services or items not covered under the Applicable Health Plan, including dental services, vision/optical services, and over-the-counter medications, vitamins, and similar items, even with a prescription, unless otherwise required by law. Vision/optical services are excluded even at Kaiser.
- **Maximum Benefits.** For Blue Shield PPO: The maximum annual HRA amount is \$2,200 for Employee Only coverage and \$4,400 for Family coverage. Unused amounts do not carry over to a subsequent Plan Year and return to the Employer. For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator. For Kaiser: The maximum annual HRA amount is \$4,500 for Employee Only coverage and \$9,000 for Family coverage. For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator.
- **Nondiscrimination.** Benefits for Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator in its sole discretion.
- **Funding of HRA Account.** The HRA is funded annually by the Employer and resets each Plan Year with the full annual benefit amount, subject to the applicable maximum benefit amount described in this Appendix B. Unused amounts do not carry over to a subsequent Plan Year and return to the Employer.
- **Carryover and Forfeitures.** If any balance remains in the Participant's HRA Account at the end of a Plan Year, such balance shall be forfeited, will not carry over to a subsequent Plan Year, and unused amounts return to Saint Mary's College of California. If a Participant ceases to be a Participant, expenses incurred after such time will not be reimbursed unless COBRA continuation coverage is elected.

Filing HRA Claims

Participants may access HRA benefits by using the benefit card or by submitting a claim for reimbursement.

- **Benefit Card.** The Claims Administrator will provide Participants with a benefit card linked to the HRA. The benefit card may be used to pay certain eligible expenses at the point of service, subject to the Claims Administrator's benefit card procedures. Benefit card transactions remain subject to substantiation and post-payment review.
- **Claim Submission.** For eligible expenses not paid by benefit card, Participants must submit a completed claim form with the applicable Explanation of Benefits, or other itemized documentation accepted by the Claims Administrator. Claims may be submitted to:

Marin Benefits Administrators
6366 Commerce Blvd., Suite 293
Rohnert Park, CA 94928
Online claim submission: www.marinbenefits.com
- **Claim Filing Deadline.** Active Participants must submit claims no later than March 31 following the end of the Plan Year in which the expense was incurred. Participants whose coverage terminates before the end of the Plan Year must submit claims within ninety (90) days following the date participation in the Plan terminates.
- Please refer to the Claims and Appeals Procedures in this SPD for further information.

Refunds/Repayments

If a Participant receives a refund, credit, or reimbursement from a provider or any other source for an expense that was previously reimbursed by the Plan (including through use of a benefit card), the Participant must promptly repay the refunded amount to the Plan (or the Claims Administrator, as directed).

Health Reimbursement Benefits

After the Participant submits a valid receipt along with a completed claim form, as proof that a covered Participant, Spouse, or Dependent has incurred Medical Care Expenses eligible for reimbursement, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Active Participant claims must be submitted no later than March 31 following the end of the Plan Year in which the expense was incurred. Terminated Participant claims must be submitted within ninety (90) days following the date participation in the Plan terminates. The amount reimbursable from the HRA Account is subject to the Coordination of Benefits section of this SPD and the Plan as applicable.

Reimbursement of Expenses - Eligible Provider

In order to be reimbursed for expenses resulting from services of a health care provider, the services generally must have been provided by a properly licensed individual who is an eligible medical services provider or individual acting under the licensed individual's supervision as a technician, and the treatment received as part of the services must have been within the scope of the licensed individual's licensure and training.

Medical Care Expenses Exclusions

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

- Expenses incurred before a Participant's effective date of coverage or after termination of coverage, except as otherwise required under COBRA or other applicable law.
- Health insurance premiums for any health plan, including the Applicable Health Plan.
- Services or items considered cosmetic under the Internal Revenue Code.
- Any expense, service, or item that is not covered under the Applicable Health Plan, or that does not otherwise satisfy the covered-expense requirements described in this Appendix B.
- Any item that does not constitute "medical care" as defined under Code §213(d).

Questions

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

Coordination of Benefits

The purpose of this Plan is to help Participants pay for certain eligible unreimbursed Medical Care Expenses. The Plan is not intended to permit any person to receive reimbursements greater than the actual eligible expenses incurred.

Benefits under this Plan will be coordinated with benefits payable under the Applicable Health Plan and any other group health plan or reimbursement arrangement, so that total reimbursements do not exceed 100% of the eligible expense incurred. The HRA will reimburse only eligible expenses that have not been reimbursed by the Applicable Health Plan or another source, subject to the terms, exclusions, substantiation requirements, and maximum benefit limits of this Plan.

Right to Receive and Release Necessary Information

In order to determine this Plan's responsibility, the Employer or Administrator may, with or without notice to you, or without your consent, give to or get from any other plan, company or person any information needed to coordinate benefits.