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University of Delaware Section 125 Plan

as Amended and Restated effective July 1, 2025

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INTRODUCTION

The University of Delaware maintains The University of Delaware Section 125 Plan (the "Plan") to provide its Eligible Employees[1] with the opportunity to choose between certain optional welfare benefits provided by The University of Delaware and cash compensation so that such Employees may select a compensation and benefits package that best meets their individual needs by allowing them to pay for their share of contributions for certain benefit plans called "Benefits Options" with pretax dollars. This document sets forth the provisions, which, together with the attachments hereto and the materials, if any, incorporated by reference herein or in any of the attachments, constitute the Plan, as amended and restated effective July 1, 2025.

The Plan has three components:

i. A Cafeteria Plan Component. The Cafeteria Plan Component allows Eligible Employees to pay for their share of certain underlying welfare benefit plans with pretax contributions.
ii. The Health Care Flexible Spending Account Plan. The health care flexible spending account plan allows an Eligible Employee to elect to use a specified amount of pre-tax contributions for unreimbursed qualified medical care expenses and is intended to qualify as a Code Section 105 self-insured medical reimbursement plan.
iii. The Dependent Care Flexible Spending Account Plan. The dependent care flexible spending account plan allows an Eligible Employee to elect to use a specified amount of pretax contributions for reimbursement of Dependent Care Expenses and is intended to qualify as a Code Section 129 dependent care assistance plan.

Although included within this document, the dependent care flexible spending account plan and the health care flexible spending account plan are each separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed under the Internal Revenue Code of 1986, as amended (the "Code").

The University of Delaware reserves the right to alter, amend, modify or terminate the Plan in whole or in part, at any time for any reason in a manner consistent with the provisions of Article VII.

This document, as it may be duly amended, together with the Appendices and Schedules hereto, as they may be duly amended, and together with the materials, if any, that the document or any of the attachments incorporates by reference, shall constitute the Plan in its entirety. In the event any discrepancies exist between or among this document, any attachment, and any amendment, the order of governance shall be as follows: the amendment, the attachment, and last, this document.

The Plan is intended to qualify as a "cafeteria plan" within the meaning of Section 125(d) of the Code, and other pertinent laws and regulations, and is to be operated and interpreted in a manner consistent with that objective. To the extent this Plan provides Eligible Employees with a choice

[1] Capitalized words have the meanings set forth in Article I unless specified otherwise.

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between cash and qualified benefits, it is intended that the nontaxable benefits that an Employee elects to receive under the Plan will be eligible for exclusion from such Employee's income for federal income tax purposes. The provisions of the Plan shall be construed, administered, and enforced according to applicable federal law and the laws of the State of Delaware.

It is intended that the Plan meet all applicable requirements of the Code and the regulations and other authority issued thereunder, and in the event of any conflict between any term or provision of this Plan and the Code, the term or provision of the Code shall be deemed controlling, and the conflicting term or provision of the Plan shall be deemed superseded only to the extent of such conflict as determined by the Plan Administrator.

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ARTICLE I

DEFINITIONS

When used in the text of this document and capitalized, the following words and phrases will have the meanings set forth below, unless the context clearly indicates otherwise.

Annual Enrollment Period

Annual Enrollment Period means the period of time preceding the beginning of each Plan Year, designated by the Plan Administrator, during which Eligible Employees may select among the options that are available under the Plan for themselves and, where applicable, their Dependents.

Benefits Option

Benefits Option means any of the plans sponsored or otherwise made available under this Plan by the University, set forth in Appendix A, as those plans may be amended from time to time.

Child Coverage Order

Child Coverage Order means a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for the child of an Eligible Employee.

Claims Administrator

Any individual, committee, third party administrator or insurance company designated by the University to review and process claims for benefits under a Benefits Option.

COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. References to COBRA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

Code

Code means the Internal Revenue Code of 1986, as amended from time to time. References to the Code include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

Compensation Reduction Amount

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Compensation Reduction Amount means, for any Plan Year, the amount by which an Eligible Employee's compensation is reduced by the University, as elected by the Eligible Employee through the Enrollment Process and applied by the University under the Plan to pay for the Benefits Options selected by the Eligible Employee before any applicable state and federal taxes have been deducted from the Eligible Employee's compensation.

Dental Coverage Benefits

Dental Coverage Benefits means those benefits that are in the nature of dental coverage or similar benefits provided through contracts or policies with a Provider or on a self- funded basis by the University. The Dental Coverage Benefits are more specifically described in such contracts or policies underlying the Dental Coverage Benefits.

Dependent

Dependent means, with respect to any Benefits Option, an individual who is a "Dependent" of an Employee under the terms of that Benefits Option. A Dependent may include a child, spouse or other individual in a dependency relationship with an Eligible Employee as set forth under the terms of the applicable Benefits Option. For purposes of the Medical, Dental, Vision, and Life Insurance Coverage Benefits and the Health FSA, Dependent includes an Eligible Employee's:

(1) Legal spouse;

(2) Child under age 26 who is a natural born child, legally adopted child, child placed for adoption, or eligible foster child of the Eligible Employee or the Eligible Employee's legal spouse;

(3) Child who does not meet the requirements of Section (2), above, if such child is unmarried, under age 19 (age 24 if a full-time student), principally resides with the Employee, is dependent on the Employee for at least 50% of his or her support and maintenance, and is considered the Employee's dependent under Section 105(b) of the Code;

(4) Child aged 26 or older if such child is unmarried, principally resides with the Employee, is totally disabled as determined by the Plan Administrator, is dependent upon the Employee for at least 50% of his or her support and maintenance and is considered the Employee's dependent under Section 105(b) of the Code. To be a Dependent under this Section (4), such child must have been totally disabled and a Dependent covered under the Plan on the day before the date the child would have otherwise lost coverage under the Plan (due to exceeding age 26) and must thereafter remain continuously totally disabled.

(5) For purposes of Section (4) above, the Plan Administrator has absolute discretion, in accordance with applicable state and federal law, to approve a child's incapacity. If approved by the Plan Administrator, the child can continue to qualify as a

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Dependent under the terms of the Plan. Proof of incapacity must be furnished to the Plan Administrator within one calendar month after coverage would otherwise terminate. The Plan Administrator reserves the right to request proof of continuance of the individual's disabled status from time to time. For purposes of obtaining that proof, the Plan Administrator reserves the right to have the child submit to an examination by a provider of its choice. The Plan Administrator also reserves the right to request proof of dependence on the Employee for support and maintenance for purposes of Sections (3) and (4), above.

(6) A child shall be treated as a child of the Eligible Employee and as a Dependent if the Employee is required to provide the child with medical coverage pursuant to the terms of a qualified medical child support order.

Dependent Care Flexible Spending Account or Dependent Care FSA

Dependent Care Flexible Spending Account means the flexible spending account established to reimburse and/or pay a Participant's eligible dependent care expenses as set forth in Schedule B.

Effective Date

Effective Date means July 1, 2025, the effective date of this amendment and restatement.

Eligible Employee

Eligible Employee means an Employee who is classified by the University as full-time, or benefits-eligible part-time (equal to or greater than 50% full-time), or a trainee Employee, who is eligible under the terms of one or more Benefits Option(s) to be covered under or to participate in such Benefits Option(s), provided the following individuals will not be considered an Eligible Employee:

(a) A leased employee within the meaning of Section 414(n) of the Code,
(b) A contract worker or independent contractor,
(c) A casual employee hired short-term to meet specific University needs, in the University's sole discretion (provided that, any employee who is excluded from eligibility on this basis shall become an Eligible Employee if he completes a sufficient number of hours of service, during a measurement period, to be classified as full-time for purposes of the Affordable Care Act),
(d) An individual paid by a temporary or other employment staffing agency, or
(e) An employee who is a member of a collective bargaining unit to which participation in this Plan has not been the subject of good faith bargaining.

Whether an individual is an Employee of the University or an independent contractor and whether an Employee of the University is a member of any particular classification of

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Employee will be determined by the University in its sole discretion, consistent with its internal policies and procedures irrespective of the treatment of any such individual for any purposes under the Code, common law, or any other law.

Employee

Employee means a person identified in and paid through the University of Delaware's (or an affiliated employer's) payroll system as a common law employee thereof, including members of the FOP, AAUP, and AFSCME collective bargaining units, if the applicable bargaining agreement provides for participation in this Plan.

Enrollment Process

Enrollment Process means the process prescribed by the Plan Administrator for the purpose of enrolling for coverage under the Plan or in a Benefits Option or for changing or waiving such coverage, including any applicable election forms relating to the Plan or a Benefits Option. The Enrollment Process may include completing a form or forms, in written, electronic or any other medium, and returning the properly completed form(s) to the Plan Administrator, or any other procedure prescribed by the Plan Administrator.

FMLA

FMLA means the Family and Medical Leave Act of 1993, as amended from time to time. References to the FMLA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

Health Benefits

Health Benefit means a Benefit Option that is a group health plan within the meaning of Section 9801 of the Code, including the Medical Coverage Benefits, Dental Coverage Benefits, Vision Coverage Benefits, and Health Care Flexible Spending Account benefits (or any combination thereof) provided by the University and payable through this Plan.

Health Care Flexible Spending Account or Health FSA

Health Care Flexible Spending Account or Health FSA means the flexible spending account established to reimburse and/or pay a Participant's eligible health care expenses, as set forth in Schedule A.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. References to HIPAA include the valid and binding governmental regulations, court decisions and other regulatory or judicial authority issued or rendered thereunder.

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Insured Benefit Option

Insured Benefit Option means any Benefits Option payable through this Plan that is funded through a group policy or contract insured by a Provider.

Life Insurance Benefits

Life Insurance Benefits means those benefits that are in the nature of life insurance benefits, including accidental death and dismemberment coverage, provided to Participants through contracts or policies with a Provider. The Life Insurance Benefits are more specifically described in such contracts or policies underlying the Life Insurance Benefits.

Long Term Disability Insurance Benefits

Long Term Disability Insurance Benefits means those benefits that are in the nature of disability insurance provided through contracts or policies with a Provider. The Long Term Disability Insurance Benefits are more specifically described in such contracts or policies underlying the Long Term Disability Benefits.

Medical Coverage Benefits

Medical Coverage Benefits means those benefits that are in the nature of medical coverage, through contracts or policies with a Provider, or on a self-funded basis by the University. The Medical Coverage Benefits are more specifically described in such arrangements, contracts or policies underlying the Medical Coverage Benefits.

Participant

Participant means any Eligible Employee who meets the requirements for participation under this Plan and for whom coverage is in effect under this Plan.

Plan

Plan means The University of Delaware Section 125 Plan, as described herein, including this document and all Appendices and Schedules, and as amended from time to time. Each attachment referenced in this document is incorporated into the Plan and made a part hereof.

Plan Administrator

Plan Administrator means the person, persons or committee identified to serve as Plan Administrator in Section 6.01.

Plan Sponsor

Plan Sponsor means the University.

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Plan Year

Plan Year means the 12-consecutive-month period beginning July 1 and ending the following June 30; provided, however, the Plan Year for the Health FSA and Dependent Care FSA shall be the 12-consecutive-month period beginning January 1 and ending the following December 31.

Prior Coverage

Prior Coverage means coverage under a group health plan or other health insurance coverage that is subject to the requirements of HIPAA, other than coverage under a Benefits Option.

Provider

Provider means, as applicable, an insurance company, or, in the case of a self-funded Benefits Option, other benefit provider that has issued a group contract for benefits or administers a self-funded contract of benefits for Participants under a Benefits Option offered under the Plan.

Qualifying Change in Status

Qualifying Change in Status means, as determined by the Plan Administrator in its sole discretion and on a uniform and consistent basis, subject to any restriction under applicable law and, with respect to any Benefits Option, any restriction set forth in the documents describing such Benefits Option, a change in:

(a) an Eligible Employee's legal marital status, including marriage, death, divorce, and legal separation;

(b) the number of an Eligible Employee's Dependents, including as a result of birth, death, adoption and placement for adoption;

(c) the employment status of an Eligible Employee or Dependent of an Eligible Employee that affects eligibility to participate in the Plan or another plan of the Eligible Employee or the Eligible Employee's Dependent, including a termination or commencement of employment, or a commencement of or a return from a leave of absence;

(d) the ability of a Dependent of an Eligible Employee to satisfy the eligibility requirements for coverage under a Benefits Option (including the attainment of age, termination or commencement of employment, or any similar circumstances);

(e) the residence of an Eligible Employee or Dependent of an Eligible Employee when the new place of residence is outside the network service area of the applicable Benefit Option in which the Eligible Employee, or Dependent of an Eligible Employee, as applicable, was enrolled prior to the change in place of residence;

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(f) with respect to any Benefits Option, a Qualifying Change in Status in accordance with the rules, if any, prescribed in the documents describing such Benefits Option; or another change that is determined by the Plan Administrator, consistent with the rules under Section 125 of the Code and the regulations promulgated thereunder, to be an occurrence in the life or work of an Eligible Employee, his spouse, or any of his Dependents that would permit the Eligible Employee to elect, waive, or change coverage under a Benefits Option under this Plan during the Plan Year.

Special Enrollment Event

Special Enrollment Event means, with respect to any Eligible Employee and any Benefits Option providing group health benefit coverage subject to the special enrollment provisions of HIPAA:

(a) the marriage of the Eligible Employee;

(b) the birth of a child of the Eligible Employee, adoption of a child by the Eligible Employee or placement of a child with the Eligible Employee for adoption; or

(c) the qualifying loss of Prior Coverage by the Eligible Employee or a Dependent. For purposes of this definition, qualifying loss means:

(1) if the Prior Coverage is provided under COBRA, as amended, the exhaustion of such coverage; or

(2) if the Prior Coverage is not described above, the loss of eligibility for such Prior Coverage or the termination of employer contributions toward the Prior Coverage.

(d) the loss of eligibility for coverage under a Medicaid Plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act; or

(e) eligibility for assistance with coverage under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act.

UDollars

UDollars means the University's contribution (other than a Participant's Compensation Reduction Amount), if any, allocated to a Participant that may be used toward the cost of the Benefits Options elected by the Participant. UDollars shall be payable in cash to a Participant, if at all, only as expressly provided under the Plan.

University

University means the University of Delaware.

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USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. References to USERRA include the valid and binding governmental regulations, court decisions and other regulatory or judicial authority issued or rendered thereunder.

Vision Coverage Benefits

Vision Coverage Benefits means those benefits that are in the nature of vision insurance or similar benefits provided through contracts or policies with a Provider or on a self-funded basis by the University. The Vision Coverage Benefits are more specifically described in such contracts or policies underlying the Vision Coverage Benefits.

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ARTICLE II

ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

Each Eligible Employee shall become eligible to participate in the Plan as follows:

(a) An Eligible Employee who was an Eligible Employee on the day before the Effective Date shall be eligible to participate in this Plan beginning on the Effective Date.

(b) Each Eligible Employee not described in Section (a) shall be eligible to participate in this Plan on the first day of the month coincident with or next following the Eligible Employee's date of hire. Coverage, if elected, will be effective as of the Eligible Employee's eligibility date.

(c) The eligibility provisions of this Section 2.01 are not intended to override any waiting period(s) or the terms of eligibility specified in the applicable Benefit Options. Eligibility for any given Benefit Option shall be determined not by this Plan, but by the terms of that Benefit Option.

2.02 Enrollment and Election of Compensation Reduction Amount

Except to the extent provided in Section 2.03, an Eligible Employee must enroll, through the Enrollment Process, in one or more Benefits Options and elect to contribute to such Benefits Options with Compensation Reduction Amounts to become a Participant in the Plan. An Eligible Employee may elect, waive, or change coverage under this Plan in accordance with and only in accordance with the provisions of this Section and the Enrollment Process. An Eligible Employee may elect only those Benefits Options that are available to his classification of employment, as described in Appendix A.

A Participant may choose under the Plan to receive the Participant's full compensation for any Plan Year in cash or to have a portion of it applied by the University toward contributions for one or more Benefits Options. Benefits under the Plan are limited to providing the Participant the opportunity to pay the employee portion of such coverage and contributions, as applicable, with Compensation Reduction Amounts and do not affect the Participant's eligibility for or benefits under any Benefits Option. The Plan Administrator may establish certain Benefits Options that must be purchased or that can be waived only if proof of other coverage is established. These Benefits Options will be purchased for the Participant through Compensation Reduction Amounts, unless the conditions for waiver have been satisfied.

While the election to reduce Compensation described above may be made under the Plan, actual benefits are provided not by the Plan but by the Benefit Options, as applicable. The types and amounts of benefits available under each such Benefit Option, the requirements

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for participating in each such Benefit Option, and the other terms and conditions of coverage and benefits under each such Benefit Option are as set forth and amended from time to time in such Benefit Options, in the group insurance contracts that constitute, or are incorporated by reference in, certain of those Benefit Options.

(a) Initial Enrollment

An individual who is newly eligible to participate in the Plan must properly complete the Enrollment Process to enroll in a Benefits Option and commence participation in the Plan. Such Enrollment Process must be completed no later than 30 days from the Eligible Employee's hire date. Participation will be effective as set forth under Section 2.01, above. If the Eligible Employee does not properly complete the Enrollment Process by the end of the applicable time period, the Eligible Employee's coverage under one or more of the Benefits Options shall be determined in accordance with the default provisions of Section 2.03.

(b) Annual Enrollment Period

Each Eligible Employee who is a Participant in the Plan or who is eligible to become a Participant in the Plan shall be notified, prior to each Plan Year, of his right to become a Participant in the Plan, to continue participation in the Plan or to modify or to cease participation in the Plan and shall be given a reasonable period of time in which to exercise such right. Such reasonable period of time shall be known as the "Annual Enrollment Period." During the Annual Enrollment Period, an Eligible Employee may enroll for, waive, or change coverage by properly completing the Enrollment Process. Such new elections shall be effective on the July 1 following the Annual Enrollment Period, or for the Health FSA and Dependent Care FSA, the January 1 following the Annual Enrollment Period. If an individual does not properly complete the Enrollment Process by the end of the Annual Enrollment Period, the Eligible Employee shall be covered under the Plan or as provided in Section 2.03.

(c) Irrevocability of Elections

Except as otherwise provided in Subsections (d) through (f) of this Section, a Participant's elections made under the Plan are irrevocable during the applicable Plan Year.

(d) Qualifying Change in Status

If an Eligible Employee experiences a Qualifying Change in Status and the Eligible Employee properly completes the Enrollment Process, which may include submitting forms substantiating the Qualifying Change in Status as required by the Plan Administrator, within 30 days after the date of the event causing the Qualifying Change in Status, the Eligible Employee may enroll for, waive, or change his coverage under the Plan provided that such election is, with respect to

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any Benefits Option, on account of and consistent with the Eligible Employee's Qualifying Change in Status and the terms of the plan documents describing that Benefits Option. An enrollment, waiver, or change in coverage under the Plan shall be consistent with a Qualifying Change in Status if it corresponds with the Qualifying Change in Status and the Qualifying Change in Status affects eligibility for coverage under the Benefits Option. The enrollment, waiver, or change in coverage shall be effective as of the date of the Qualifying Change in Status; provided, however, any change in the Employee's Compensation Reduction Amount required to pay for the newly selected Benefits Options (if any) shall be calculated for the month in which the Qualifying Change in Status occurs.

There is no limit to the number of Qualifying Changes in Status that can occur during a Plan Year.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall make all determinations as to whether a Qualifying Change in Status has occurred and whether a requested change in coverage is on account of and consistent with a Qualifying Change in Status. In addition, the Plan Administrator may require certain specific consistency requirements to be met for a Participant to be able to revoke an election with respect to a Benefits Option and make a new election based on the specified Change in Status.

(e) Special Enrollment Rules

If an Eligible Employee or the Eligible Employee's spouse or dependent is entitled to special enrollment rights under any Health Benefit, as required by HIPAA under Section 9801(f) of the Code, the Employee may revoke an election and make a new election under the Plan whenever a Special Enrollment Event occurs, provided that the Eligible Employee properly completes the Enrollment Process within 30 days of the date on which the Special Enrollment Event occurs (or within 60 days on account of termination of eligibility for or eligibility for assistance with Medicaid or a State child health plan). Such enrollment shall be effective as of the following date:

(1) If the Special Enrollment Event is the birth, adoption, or placement for adoption of a child of the Eligible Employee, enrollment shall be effective as of the date of the Special Enrollment Event.

(2) If the Special Enrollment Event is not described in Section (1), above, enrollment shall be effective as of the first day of the month following the month in which the Special Enrollment Event occurs.

(f) Other Mid-year Changes

An Eligible Employee may change his elections under this Plan and a Benefits Option in accordance with the events specified in the plan documents describing

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the Medical Coverage Benefits to the extent those events and the resulting election changes are consistent with Section 125 of the Code.

The above notwithstanding, an Eligible Employee may change his elections under this Plan and a Benefits Option in accordance with the following terms, but subject to any restrictions of applicable law, and with respect to any Benefits Option, any restrictions, rules, or conditions in the plan document describing such Benefits Option:

(1) If the cost to an Eligible Employee of a Benefits Option increases significantly during a Plan Year, the Eligible Employee may make a corresponding change in his elections under this Plan, including commencing participation in a Benefits Option, with a decrease in cost or, in the case of an increase in cost, revoking an election for coverage, and in lieu thereof, either receiving, on a prospective basis, coverage under another Benefits Option providing similar coverage or dropping coverage if no other Benefits Option providing similar coverage is available; provided, however (a) for the Dependent Care FSA, the cost must not be a change in the cost of a provider who is a relative; and (b) a change in cost is not a recognized permissible mid-year change event with respect to the Health FSA.

(2) If coverage under a Benefits Option is significantly curtailed, a Participant who has an election of that Benefits Option in effect may cancel, waive, or change coverage.

(3) If a Participant meets or exceeds a lifetime limit on all benefits under a Benefits Option, the Participant may cancel coverage and elect new coverage.

(4) If an Eligible Employee or any of his Dependents loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

(i) A State children's health insurance program under Title XXI of the Social Security Act;

(ii) A medical care program of an Indian Tribal government, the Indian Health Services, or a tribal organization;

(iii) A State health benefits risk pool; or

(iv) A foreign government group health plan;

the Eligible Employee may make a corresponding prospective election change under this Plan and an applicable Benefits Option.

(5) If a Child Coverage Order requires the coverage of an Eligible Employee's

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child under a Benefits Option for accident or health coverage, an Eligible Employee may change his election to provide for such coverage.

(6) If a Child Coverage Order requires the spouse or former spouse of an Eligible Employee to provide accident or health coverage to the Eligible Employee's child, and the coverage is, in fact, provided, the Eligible Employee may change his election to cancel the child's coverage.

(7) If an Eligible Employee or Dependent of an Eligible Employee becomes entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under Section 1928 of such Act, the Eligible Employee may change his election to cancel or reduce coverage for the individual so entitled to such coverage under a Benefits Option providing accident or health coverage.

(8) If an Eligible Employee or Dependent of an Eligible Employee who is entitled to coverage under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely relating to the distribution of pediatric vaccines under Section 1928 of such Act, loses eligibility to receive such coverage, the Eligible Employee may elect to commence or increase coverage for the individual who loses such eligibility to coverage under a Benefits Option providing accident or health coverage.

(9) Notwithstanding anything in this Plan to the contrary, no Eligible Employee may change his election under Sections 2.02(f)(1) through (4) of the Plan with respect to the Health Care Flexible Spending Account, as set forth in Schedule A.

(10) Notwithstanding anything in this Plan to the contrary, no Eligible Employee may change his election under Section 2.02(f)(4) through (8) of the Plan with respect to the Dependent Care Flexible Spending Account as set forth in Schedule B.

(11) A Participant's or other Eligible Employee's change in elections under this Section 2.02(f) shall be effective only if the Eligible Employee properly completes the Enrollment Process effecting such change within 30 days of the event that permits the change.

(12) Except as otherwise provided herein, any change made under this Section 2.02(f) shall be effective prospectively only.

(13) The Plan Administrator shall make all determinations under this Section 2.02(f) in its sole discretion, including determinations as to whether a change in cost or coverage is significant and whether a loss of coverage

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has occurred.

The Plan Administrator may determine, in its sole judgment, but in accordance with Section 125 of the Code and the regulations promulgated thereunder to prescribe rules to permit changes in election during a Plan Year under other circumstances.

2.03 Failure to Elect

If a newly Eligible Employee fails to properly complete the Enrollment Process within the applicable period described in Section 2.02(a), the Eligible Employee shall automatically be deemed to have elected Compensation Reduction Amounts under the Plan to be covered by the following Benefits Options:

(a) Medical Coverage Benefits – Employee Only, least expensive medical plan.

¶

(b) Dental Coverage Benefits - Employee only

(c) Vision Coverage Benefits - No coverage

(d) Long Term Disability Insurance Benefits - Standard

(e) Life Insurance Benefits - 2x benefits base salary

If an Eligible Employee fails to properly complete the Enrollment Process by the end of the Annual Enrollment Period described in Section 2.02(b), the Eligible Employee shall be deemed to have made the same elections, or deemed elections under this Section, with respect to the benefits under such Benefits Options, as applicable, as was in effect for the Participant just prior to the end of the preceding Plan Year or any other default election specified in the Annual Enrollment Period materials for such Plan Year, and such Participant also shall be deemed to have agreed to Compensation Reduction Amounts for the subsequent Plan Year equal to the Participant's share of the cost from time to time during such Plan Year of each such Benefits Options that the Participant is deemed to have elected for such Plan Year; provided that no coverage under this Plan shall be provided and no contributions made with regard to the following Benefits Options:

- Health Care FSA
- Dependent Care FSA

Coverage provided by default under this Section shall, for all purposes under the Plan, be treated as if it had been elected by an Eligible Employee. Accordingly, an Eligible Employee who does not wish to participate in the Plan must affirmatively waive coverage; otherwise, the default coverage provisions of this Section 2.03 shall apply. An Eligible Employee may change such coverage as provided in Section 2.02.

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2.04 Enrollment

The Plan Administrator shall prescribe as part of the Enrollment Process one or more electronic and/or paper enrollment forms or other procedures for purposes of enrolling, changing or waiving coverage. The Enrollment Process shall require an Eligible Employee to make such elections as are necessary for the Plan Administrator to determine and effect the coverage to be provided to the Eligible Employee under the applicable Benefits Options including the amount to pay as a Compensation Reduction Amount for the elected Benefits Option. Subject to Section 6.02(g), no election by an Eligible Employee to enroll for, change, or waive coverage under the Plan shall be effective unless the election is made pursuant to the Enrollment Process and is timely completed with the Plan Administrator.

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ARTICLE III

TERMINATION OF BENEFITS

3.01 Cessation of Participation

(a) A Participant shall cease participation in the Plan upon the earliest of the following:

(1) the date of termination of this Plan;

(2) the date as of which this Plan is amended to terminate benefits with respect to a classification of Employees of which the individual is a member;

(3) with respect to a Benefits Option,

(i) the date as of which the Benefits Option ceases to be offered in connection with this Plan;

(ii) the date as of which the individual's coverage terminates under the Benefits Option; or

(iii) the end of the period for which the Participant made the last required contributions.

(4) the last day of the month in which the individual elects to cease participating in this Plan, provided that the election is made in accordance with the rules of Article II;

(5) the date on which the individual dies;

(6) the last day of the month in which the individual ceases to be an Eligible Employee;

(7) the last day of the month in which the individual enters the armed forces of any country on active, full-time duty.

(b) A Dependent shall cease participation in the Plan upon the earliest of the following:

(1) the date of termination of this Plan;

(2) with respect to a Benefits Option,

(i) the date as of which the Benefits Option ceases to be offered in connection with this Plan;

(ii) the date on which the individual ceases to qualify as a Dependent

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under the terms of the Benefits Option; or

(iii) the end of the period for which the Participant made the last required contributions.

(3) the date on which Dependent dies;

(4) the last day of the month in which the Eligible Employee dies;

(5) the last day of the month in which the Eligible Employee elects to terminate coverage for the Dependent under a Benefits Option, consistent with the terms of the Benefit Option;

(6) the last day of the month in which the individual enters the armed forces of any country on active, full-time duty.

(c) Notwithstanding any other provision of the Plan to the contrary, the cessation of a Participant's participation under the Plan with respect to the Medical Coverage Benefits will comply with the requirements of Section 2712 of the Public Health Service Act (regarding restrictions on rescissions), as incorporated by reference into Section 9815 of the Code, in accordance with rules and procedures established by the Plan Administrator or its delegate.

3.02 Coverage while on Family and Medical Leave

An Eligible Employee may participate in the Plan during a period of family or medical leave of absence from the University in accordance with and only to the extent provided under the University's policy and as required by the FMLA, or other applicable law. The Eligible Employee shall be required to pay for such coverage before, during or after the leave in accordance with such rules as the University may prescribe, according to one of the payment methods set forth below.

(a) Initial FMLA Election

(1) A Participant who takes an approved unpaid leave of absence under the FMLA shall cease to participate in the Plan unless the Employee elects to continue to participate in the Plan for the period of the unpaid leave.

(2) If the Participant elects to continue to participate in the Plan, the Participant shall continue to be covered under each Benefits Option that the Participant elects and shall be responsible for paying for the cost of such coverage in accordance with the terms of Section (b). With respect to the Benefits Options that the Participant does not elect to continue, the Participant's coverage shall cease.

(3) If the Participant elects not to continue to participate in the Plan, the Participant's coverage under all Benefits Options shall cease.

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(4) A Participant who takes an approved paid leave of absence under the FMLA shall continue to participate in the Plan in accordance with the Participant's then applicable coverage elections, subject to the terms and conditions of the Plan and, for each Benefits Option, the plan documents describing such Benefits Option.

(b) Payment for Coverage during FMLA Leave

An Employee who elects to continue coverage under a Benefits Option during an FMLA leave under Section (a)(2) may pay for coverage during the leave in accordance with the following rules, as determined by the University:

(1) The contributions due during FMLA leave may be paid based on the same schedule as payments would have been due had the Participant not been on FMLA leave, on the same schedule as payment for COBRA continuation coverage is made, under the University's existing rules for payment by Participants on leave without pay, or on any other schedule voluntarily agreed on by the Plan Administrator and the Participant. If the Employee fails to remit a scheduled payment on time, the Employee's coverage shall continue during the leave provided that the Employee shall be required to pay for such coverage upon returning from the leave. If the Employee does not return to work upon termination of the leave, the Employee's coverage shall cease and the Employee shall be liable for the cost of coverage for the period for which he has not made payment.

(2) The contributions due during FMLA leave may be paid when the Employee returns to active employment following the end of the FMLA leave. If the Employee does not return to work at the termination of the leave, the Employee shall be liable for the cost of coverage for the period of the leave.

(c) Flexible Spending Account Plan Coverage

(1) If a participant in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account takes a FMLA leave and returns from the leave during the same Plan Year, the University may require that the Employee be reinstated in coverage.

(2) If Health Care Flexible Spending Account coverage is continued during the FMLA leave, the full amount of elected Health Care Flexible Spending Account coverage will be available during the leave.

(3) If Health Care Flexible Spending Account coverage is terminated during the FMLA leave, the Employee may not be reimbursed for claims incurred during the leave.

(4) Dependent Care Flexible Spending Account coverage shall not be

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continued during the FMLA Leave if the individual is no longer eligible for the Dependent Care Flexible Spending Account.

(5) An Employee on FMLA leave has rights that are at least as great as a Participant on non-FMLA leave.

3.03 Coverage Following Severance

Coverage for an individual shall be continued during a period for which the individual is entitled to severance benefits from the University to the extent and only to the extent provided under a Benefits Option or applicable severance agreement.

3.04 COBRA

Notwithstanding any other provision of this Section to the contrary, an Eligible Employee, a former Eligible Employee, or any of his Dependents are entitled to COBRA continuation coverage under any Benefits Option that is a group health plan as provided under COBRA. An Eligible Employee, a former Eligible Employee, or any of his Dependents who elects to continue coverage as a result of a qualifying event under COBRA shall not be permitted to switch to an alternative Benefits Option solely as a result of the occurrence of the qualifying event. Except as provided in a plan document describing a Benefits Option, no University contributions shall be made toward the cost of COBRA continuation coverage, and except as otherwise provided herein, no individual shall make payment for COBRA continuation coverage under this Plan. The Eligible Employee, former Eligible Employee, or Dependent may pay for such coverage in accordance with rules that the Plan Administrator prescribes.

3.05 Reinstatement of Coverage

Notwithstanding anything in this Plan to the contrary, if an Eligible Employee who terminates employment with the University or otherwise ceases to be an Eligible Employee in a Plan Year again becomes an Eligible Employee within that Plan Year, the Eligible Employee shall automatically be reinstated in the coverage that was in effect for him at the time he ceased to be an Eligible Employee, provided that:

(a) Subject to Section (b), if the individual has ceased to be an Eligible Employee for at least 30 days, the individual may elect to change his coverage as if he has had a Qualifying Change in Status; and

(b) For any Benefits Option, the rules governing the Eligible Employee's reinstatement in and change in election of coverage shall be consistent with the terms of the plan document describing such Benefits Option.

3.06 Qualified Military Service Under USERRA

A Participant who is absent while performing "qualified military service," as defined in

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USERRA, may elect to continue participation in any Benefits Option that is a group health plan for the lesser of 24 months or until the Participant either fails to apply for reinstatement or fails to return to employment within the time required by USERRA. The Participant is responsible for making contributions under any such Benefits Option for which Participant contributions are required during the period of qualified military service in a manner determined by the Plan Administrator and pursuant to the provisions of such Benefits Option.

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ARTICLE IV

BENEFITS, FUNDING, AND CONTRIBUTIONS

4.01 Funding

The cost of coverage under the component Benefits Options elected by each Participant shall be funded by the Participant's Compensation Reduction Amount and UDollars, if applicable. The contribution and allocation of these amounts shall be made in accordance with the following rules:

(a) The Participant's cost for coverage shall be determined in accordance with the election of Benefits Options made by the Participant under the election process and will be made known to the Participant in the Enrollment Process. The Participant's Compensation Reduction Amount shall equal the required contributions for the Benefits Options Participant has elected, less allocated UDollars, if applicable, designated by the University for the Benefits Options.

(b) To the extent set forth in the plan documents describing a Benefits Option, the allocation of amounts may take the form of a bookkeeping entry until the time payment is required.

(c) If a Participant's Dependent who is covered under a Benefits Option loses eligibility under the Benefits Option, the Participant's required payment for coverage, to the extent attributable to such Dependent, shall not change until the Plan Administrator has been informed of such loss of eligibility, recognizes that the loss of eligibility permits an election change under the terms of the Plan and has a reasonable opportunity to process the change, notwithstanding the fact that coverage may have terminated upon the loss of eligibility.

(d) The amount that the University contributes, if any, based on a Participant's Compensation Reduction Amount shall be in addition to other amounts that the University, in its sole discretion, decides to contribute toward the cost of the elected Benefits Option.

(e) A Participant's Compensation Reduction Amount and UDollars allocation, if applicable, and any limitation thereof shall be prorated to reflect participation during a period shorter than the entire Plan Year.

(f) All amounts required to be paid by a Participant shall reduce the Participant's compensation for each pay period in as nearly equal amounts as the Plan Administrator deems practicable, except as the Plan Administrator shall otherwise determine.

(g) The Participant's Compensation Reduction Amount and UDollars, if applicable, associated with a Benefits Option shall be described in the enrollment forms or

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other materials distributed to Eligible Employees, at the time of their initial eligibility to enroll, or in connection with the Annual Enrollment Period, Qualifying Change in Status, Special Enrollment Event, or other event relating to a mid-year change in coverage.

(h) The maximum Compensation Reduction Amount that a Participant may elect under the Plan will be the sum of (1) the maximum Compensation Reduction Amounts that the Participant may elect to contribute to the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account, as applicable, and (2) the Employee cost from time to time of the most expensive benefits available to the Participant under the other Benefits Options.

4.02 Provision of Benefits

(a) The University shall have the right to enter into one or more contracts with one or more insurance companies or other Providers for the purposes of providing any Benefits Options offered under the Plan and to replace any of such insurance companies, Providers, 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 shall be retained by the University. The University will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan.

(b) Each Participant shall be provided the coverage under the Benefits Options that the Participant has elected or is deemed to have elected under the Plan. The types and amounts of benefits available under each Benefits Option, the requirements for participating in each such Benefits Option, and the other terms and conditions of coverage under each such Benefits Option, provided under the Plan, to the extent not specifically described herein, are as set forth and amended from time to time in the insurance policies, Provider contracts, or other agreements created under the Plan which are incorporated herein by reference and made available to Plan Participants. Any restrictions, limitations, and additional requirements relating to a Participant's entitlement to benefits that are not set forth in the Plan are described in the separate documents for the specific Benefits Option. The Provider shall provide the benefits due under the respective Benefits Option directly to the Participant, Dependents or named beneficiaries, if appropriate, according to the terms of such Benefits Option. The only benefits available under an Insured Benefit Option are those provided by the Provider pursuant to the terms of the applicable policy or contract. In no event shall the University provide a benefit under an Insured Benefits Option. Benefit Options that are currently available to Participants are set forth in Appendix A, which may be amended from time to time.

4.03 Duration of Election

Each compensation reduction agreement and each election, or waiver of a Benefits Option

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under Section 2.02, shall remain in effect until affirmatively revoked or changed by an Eligible Employee or until the Eligible Employee's participation in the Plan is terminated under Section 3.01, provided that such election may be modified to the extent provided in Sections 2.02 and 8.02. No Benefits Option election may be revoked by any Participant during the Plan Year for which it is effective, except as provided in Article II.

4.04 UDollars

(a) Subject to applicable nondiscrimination requirements, the amount of UDollars and the allocation of UDollars to a Participant will be determined from time to time by the University for both full-time benefits Eligible Employees and part-time benefits Eligible Employees. The amount of a Participant's required payment for the election of a Benefits Option will be determined based on the balance between UDollars available to the Participant based on the Benefits Options elected and the total amount of contributions required by the University for any such Benefits Option.

(b) Eligible Employees entitled to UDollars who waive Medical Coverage Benefits and/or Dental Coverage Benefits receive an amount that may be used to offset the cost of the elected Benefits Option. If not used toward the cost of the elected Benefits Option, the amount will be paid to the Employee as taxable compensation.

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ARTICLE V

PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to payment under any Benefits Option, a Participant must comply with the rules established for claiming such benefits, including, without limitation, use of identification cards, completion and filing of claim forms, authorizations, consents, and proof of loss when required as prescribed under the terms and conditions of such Benefits Option. The Participant must also furnish any pertinent information requested by the Plan Administrator.

5.02 Assignment of Benefits

Except to the extent permitted in any Benefits Option, no benefits under the Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, and the University.

5.03 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his current address. The Plan Administrator and the University shall have no obligation or duty to locate a Participant.

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ARTICLE VI

ADMINISTRATION OF THE PLAN

6.01 Administration of the Plan

The University shall serve as Plan Administrator, responsible for the administration of the Plan and shall have full discretionary authority to make all determinations regarding eligibility and contributions under the Plan, determinations of facts, and shall control and manage the operation and administration of the Plan. The University may assign or delegate any of its responsibilities as Plan Administrator or for carrying out the Plan's provisions. To the extent of any such assignment or delegation, the assignee or delegate shall have all of the authority and powers of the University. Any action taken by the University in assigning any of its responsibilities as Plan Administrator to specific persons who are directors, officers, or employees of the University shall not constitute delegation of the University's responsibility, but rather shall be treated in the manner in which the University has determined internally to discharge such responsibility.

6.02 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

(a) to have the authority and discretion to interpret the Plan, to decide questions and disputes, make factual determinations, to supply omissions, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;

(b) to authorize its agents to execute or deliver any instrument or make payments on the Plan Administrator's behalf;

(c) to obtain from Participants and others such information as shall be necessary for the proper administration of this Plan;

(d) to appoint other committees with such authority and powers as the Plan Administrator deems necessary;

(e) to retain counsel, employ agents, and provide for such clerical, accounting, actuarial, consulting, claims processing, and other services as it deems necessary or desirable to assist it in the administration of this Plan;

(f) to make and to retain the right, authority, and discretion to make claim determinations and to review and make determinations upon review of any claim denial;

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(g) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any election or other submission requiring a written form may be made telephonically or electronically and whereby elections or submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;

(h) to adopt rules for the administration of the Plan; and

(i) to maintain records of administration of the Plan or affected Benefits Option.

No determination of the Plan Administrator in one case shall create a bias or retroactive adjustment in any other case. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons and entitled to the maximum deference allowed by applicable law. Expenses for the administration of the Plan shall be paid by the University or, at the University's discretion, the Plan or a Benefits Option, to the extent such expenses are attributable to such Benefits Option.

6.03 Claims Procedure

With respect to claims arising under this Plan, a Participant shall submit claims to the Plan Administrator as soon as possible following the occurrence of the event on which the claim is based. The Plan Administrator shall review such claim and respond thereto within a reasonable time. The Plan's claim review procedures shall only apply to issues germane to certain benefits available under this Plan (e.g., such as a determination of a Change in Status; change in costs or coverage; or eligibility and participation matters under this Plan document). With respect to claims for benefits arising under any Benefits Option, a Participant shall submit claims in accordance with the claims procedure of such plan.

6.04 Records and Reports

The Plan Administrator shall maintain all such books, accounts, records and other data as may be necessary for the proper administration of this Plan.

The Plan Administrator shall make available to each Participant for examination at reasonable times during normal business hours such records under the Plan in its possession as pertain to him.

6.05 Coordination with Benefits Options

To the extent necessary or appropriate, the Plan Administrator shall coordinate its determinations and responsibilities with the plan administrator or administrators of the Benefits Options in accordance with such rules as the Plan Administrator and such other plan administrator or administrators shall determine.

6.06 Responsibility for Administration

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The University and its employees shall not be liable for any loss due to an error or omission in the administration of the Plan unless the loss is due to actions they have taken that are fraudulent, in bad faith, or with respect to any Benefits Options, in violation of the standards of responsibility for administration set forth in the Benefits Options. The University and its employees may rely upon information from any source assumed reasonable and in good faith to be correct.

6.07 Indemnification

To the extent permitted by law, the University shall indemnify and hold harmless each director, officer, or employee of the University to whom administrative responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under this Plan, other than such liabilities, costs and expenses as may result from the willful misconduct of any such person or amounts paid by such person in a settlement to which the University does not consent. The University may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any administrative responsibility with respect to this Plan from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under this Plan.

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ARTICLE VII

DURATION AND AMENDMENT OF THE PLAN

7.01 Right to Amend

The University reserves the right to amend, modify, or change the Plan at any time, in whole or in part, in any manner and for any reason, including, without limitation, the right to amend the Plan to reduce, add to, change or modify the Benefits Options available to any and all Participants. Any amendment shall be formally adopted in writing or made in such other manner as permissible under applicable law and any governing rules, regulations or documents relating to University governance. The University reserves the right to delegate this authority to amend, in whole or in part, to any committee, office, officer, or other person or persons as it deems appropriate.

7.02 Right to Terminate

Although the University intends to maintain this Plan for an indefinite period, the University reserves the absolute right, without limitation, to terminate or partially terminate the Plan at any time, for any reason by or pursuant to a resolution of the University or in such other manner as permissible under applicable law and any rules, regulations or documents relating to University governance. Any termination or partial termination of the Plan shall not adversely affect the participation of a Participant prior to the date of the termination or partial termination.

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ARTICLE VIII

MISCELLANEOUS

8.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the University and any of its Employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of such an Employee to perform his duties in a satisfactory and businesslike manner, nor shall it affect the University's right to discipline, discharge, or take any other action with respect to such an Employee. Neither the establishment of the Plan nor any provision thereof may be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator or the University or its officers or Employees, except as expressly provided herein or by law.

8.02 No Vested Right

No Employee of the University, whether or not a Participant in, or eligible to participate in, the Plan has at any time any vested rights to benefits provided under the Plan or any Benefits Option.

8.03 Adjustments and Legal Compliance

Notwithstanding anything in this Plan to the contrary, the University may conduct retrospective audits of benefits up to a five-year lookback period. Based on audit results, the University may prospectively limit, reallocate or deny any benefit for a Participant or any group of Participants (including through amending Compensation Reduction Amounts) to the extent necessary to avoid discrimination under or otherwise, to comply with any pertinent provision of the Code or other applicable law, including without limitation:

(a) The Plan Administrator may make adjustments to a Participant's benefit election and benefit payment amount to the extent necessary to maintain the compliance of the Plan or any of the Benefits Options with applicable provisions of the Code or any other applicable law.

(b) Subject to the provisions of the Code and other applicable law, the Plan Administrator may adjust a Participant's Compensation Reduction Amount to provide the Participant with the coverage that the Participant has elected and to account for changes in the cost of such coverage.

(c) If for any reason, a Participant's Compensation Reduction Amount is under charged and/or UDollars are overpaid erroneously, the Participant shall be responsible for the undercharged amount or for refunding the overpayment to the University, as applicable. The refund may be in the form of a lump sum payment, payroll deduction, or any other method as the Plan Administrator, in its sole discretion and under IRS

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regulations may require. Notwithstanding the foregoing, benefits available through a fully insured Benefits Option, such as dental and vision benefits, may have different refund rules and may limit the availability of obtaining a refund to a specified timeframe (e.g., 60 days of the qualifying event) and whether any claims were paid during the time period for which the refund is requested, as more fully specified in the University's applicable internal policies and procedures.

8.04 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and with the laws of the State of Delaware and any dispute concerning the Plan or benefits shall be subject to the exclusive jurisdiction of the state and federal courts located in the State of Delaware. Coverage under Benefits Options available under this Plan are intended to be exempt from taxation under Section 125 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable for purposes of retaining such tax exemption.

8.05 No Guarantee of Tax Consequences

Notwithstanding any provision of this Plan to the contrary, the University and the Plan Administrator make no commitment or guarantee that any amounts paid to or for the benefit or coverage of a Participant under this Plan shall be excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other particular federal, state or local tax treatment shall apply or become available to any Participant as a result of the operation of this Plan.

By accepting coverage under this Plan, a Participant agrees to be liable for any tax that may be imposed with respect to coverage or benefits hereunder, plus any interest or penalties that may be imposed in connection with the tax and agrees that no Participant will have any recourse against the Plan Administrator or University with respect to any increased taxes or other losses or damages suffered as a result thereof.

8.06 Provision of Evidence

For purposes of making determinations with respect to eligibility for or the payment of benefits or the opportunity to make mid-year changes in election, or for any other purpose under the Plan, the Plan Administrator may require any Eligible Employee or other affected individual to submit or cause to be submitted whatever proof or evidence the Plan Administrator may reasonably require (either directly to the Plan Administrator or to any person delegated by it).

8.07 Invalid Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

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8.08 Privacy

The University is committed to protecting the privacy of personally identifiable information and will take appropriate measures to keep such information confidential.

8.09 Health Insurance Portability and Accountability Act

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

8.10 Uniform Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

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EXECUTED on behalf of the University of Delaware by its duly-authorized officer this 24 day of July, 2026.

UNIVERSITY OF DELAWARE

Signed by:
By: Melissa Bard
0692E85ACA4841E...
Name: Melissa Bard
Title Vice President and CHRO
7/24/2026

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APPENDIX A

This Appendix reflects information as of July 1, 2025.

Plan Information Summary

1.	Name, address and phone number of Plan Sponsor:	The University of Delaware 550 S. College Ave Newark, DE 19713
2.	Name, address and phone number of Plan Administrator:	The University of Delaware 550 S. College Ave Newark, DE 19713
3.	Federal Tax Identification	51-6000297
4.	Controlling Law:	DE
5.	Plan Number:	[501]
6.	Amended and Restated Date:	July 1, 2025
8.	Plan Year:	The 12-consecutive-month period beginning July 1 and ending the following June 30; provided, however, the Plan Year for the Health FSA and Dependent Care FSA shall be the 12-consecutive-month period beginning January 1 and ending the following December 31
11.	Third Party Administrator for the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan:	ASIFlex 201 W. Broadway, #4C, Columbia, MO 65203
12.	COBRA Administrator for the Health Care Flexible Spending Account Plan:	ASI COBRA PO Box 657 Columbia, MO. 65205-0657

Benefits Options[2]: The Plan allows Eligible Employees to use tax free dollars to pay for certain benefit expenses under various benefit programs. The University elects to offer to Eligible Employees the following Benefit Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Plan Options. These Benefit Plan Option(s) are specifically incorporated herein by reference.

[2] Note to UD: Please confirm this remains accurate.

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1. Health and Prescription Drug Plan (self-insured with Highmark and Aetna)

2. Dental Plan (fully insured with MetLife)

3. Vision Plan (fully insured with National Vision Administrators)

4. Life Insurance/Accidental Death and Dismemberment Plan (fully insured with MetLife)

5. Long Term Disability Plan (fully insured with MetLife - exempt employees only)

8. Supplemental Long Term Disability Plan (fully insured with The Hartford for Delaware Employees' Pension Plan Participants)

9. [University of Delaware Health Care Flexible Spending Account Plan, as more fully described on Schedule A hereto

10. University of Delaware Dependent Care Flexible Spending Account Plan, as more fully described on Schedule B hereto][3]

[3] Note to UD: Are there summary materials provided to employees with respect to each of the HCFSA or the DCFSA that we would want to incorporate into the Schedules by reference?

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Schedule A

University of Delaware
Health Care Flexible Spending Account Plan
Amended and Restated effective July 1, 2025

INTRODUCTION

The University of Delaware maintains the University of Delaware Health Care Flexible Spending Account Plan (the "Health FSA Plan") to provide for the reimbursement of certain health care expenses to its eligible employees. This Schedule A to the University of Delaware Section 125 Plan sets forth the provisions of the Health Care Flexible Spending Account Plan, as amended and restated effective July 1, 2025, and for purposes of the Code, this Schedule A constitutes a separate written plan providing for the reimbursement of certain health care expenses.

This Health FSA Plan provides solely for the for reimbursement of health care expenses.

This Health FSA Plan is intended to qualify as an "accident and health plan" within the meaning of Section 105(e) of the Code, and any other pertinent laws or regulations, so that the benefits provided under the Health FSA Plan shall be eligible for exclusion from each Employee's income for federal income tax purposes under Section 105(b) of the Code. The provisions of this Health FSA Plan shall be interpreted in accordance with that intent.

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ARTICLE I

DEFINITIONS

As used in this Schedule A, the following terms have the meanings set forth below. Other capitalized terms used herein that are not defined below are defined in the Section 125 Plan.

Annual Enrollment Period

Annual Enrollment Period means the period of time preceding the beginning of each Plan Year, designated by the Plan Administrator, during which Eligible Employees may elect to participate in the Health FSA Plan and elect a Compensation Reduction Amount to contribute to the Health FSA Plan.

Dependent

Dependent means an Employee's:

(a) Spouse;

(b) Child (natural born child, legally adopted child, child placed for adoption, stepchild and eligible foster child), up to the last day of the month in which the child attains age 26;

(c) Child who does not meet the requirements of Section (b) above, if such child is unmarried, under age 19 (age 24 if a full-time student), principally resides with the Employee, is dependent on the Employee for at least 50% of his or her support and maintenance, and is considered the Employee's dependent under Code Section 105(b);

(d) Child aged 26 or older if such child is unmarried, principally resides with the Employee, is totally disabled as determined by the Plan Administrator, and isdependent upon the Employee for at least 50% of his or her support and maintenance and is considered the Employee's dependent under Section 105(b) of the Code. To be a Dependent, such child must have been totally disabled and a Covered Individual on the day before the date the child would have otherwise lost coverage under the Plan and must thereafter remain continuously totally disabled; and

(e) Any other individual who is a dependent of the Employee within the meaning of Code Section 152 as such section is modified by Code Section 105(b), by regulation or otherwise. A child shall be treated as a Dependent if the Employee is required to provide the child with medical coverage pursuant to the terms of a qualified medical child support order.

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Grace Period

Grace Period means the period beginning on the first day following the last day of the Plan Year and ending on the 15th day of the third month following the last day of the Plan year.

Health Care Expense

Health Care Expense means any amount Incurred by a Participant or his or her Dependent after the date the Participant's participation in the Health FSA Plan begins that is an expense for medical care within the meaning of Section 105(b) of the Code, and is identified by the University as eligible for reimbursement under the Health FSA Plan, excluding expenses reimbursed by any other health care plan, premiums paid for any other health care coverage and other expenses for which coverage under this Health FSA Plan is proscribed by the Code or other applicable law. An amount incurred that is merely beneficial to the general health of an individual is not a Health Care Expense. Over-the-counter drugs and menstrual products will be considered a Health Care Expense. The University shall determine whether any other amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

Health FSA Plan

Health FSA Plan means the University of Delaware Health Care Flexible Spending Account Plan, as described herein in this Schedule A and as may be amended from time to time.

Incurred

Incurred means provided with the health care services or supplies giving rise to the claimed expense, not when the expense is formally billed, charged, or paid.

Participant

Participant means any Eligible Employee who meets the requirements for participation under this Health FSA Plan and for whom coverage is in effect under this Health FSA Plan or a Qualified Beneficiary who has elected continuation coverage under Section 3.05 and for whom coverage is in effect under this Health FSA Plan.

Plan Year

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

Qualified Beneficiary

Qualified Beneficiary means a qualified beneficiary under COBRA.

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Qualifying Change in Status

Qualifying Change in Status means a "Qualifying Change in Status" within the meaning of the Section 125 Plan.

Section 125 Plan

Section 125 Plan means The University of Delaware Section 125 Plan, to which this Health FSA Plan is a scheduled, as amended from time to time, and any other plan sponsored by the University which is intended to comply with Section 125 of the Code and with respect to which this Health FSA Plan is a qualified benefit within the meaning of Section 125(f) of the Code.

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ARTICLE II

ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

An Eligible Employee shall be eligible to participate in this Health FSA Plan as of the date the Eligible Employee is eligible to participate in the Section 125 Plan.

2.02 Plan Enrollment

Except to the extent provided in Section 2.03, an Eligible Employee must enroll in coverage to become a Participant in the Health FSA Plan. An Eligible Employee may elect, waive, or change coverage under this Health FSA Plan in accordance with and only in accordance with the provisions of this Section.

(a) Initial Enrollment

An individual who is newly eligible to participate in the Health FSA Plan must properly complete the Enrollment Process to enroll in the Health FSA Plan and commence participation in the Health FSA Plan. The Enrollment Process must be completed no later than 30 days after becoming eligible.

If the Eligible Employee does not properly complete the Enrollment Process by the applicable time period, the Eligible Employee shall not be covered under the Health FSA Plan.

(b) Annual Enrollment Period

Each Eligible Employee who is a Participant the Health FSA Plan or who is eligible to become a Participant in the Health FSA Plan shall be notified, prior to each Plan Year, of his right to become a Participant in the Health FSA Plan, to continue participation in the Health FSA Plan, or to modify or to cease participation in the Health FSA Plan and shall be given a reasonable period of time in which to exercise such right. Such reasonable period of time shall be known as the "Annual Enrollment Period." During the Annual Enrollment Period, an Eligible Employee may enroll for, waive, or modify the rate of his contributions by properly completing the Enrollment Process. Such new election shall be effective on the January 1 following the Annual Enrollment Period. If an Eligible Employee does not properly complete the Enrollment Process by the end of the Annual Enrollment Period, the Eligible Employee shall not be covered under the Health FSA Plan.

(c) Qualifying Change in Status

Subject to any provisions set forth in this Health FSA Plan, an Eligible Employee

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shall be permitted to change coverage under this Health FSA Plan during a Plan Year upon a Qualifying Change in Status or other event in accordance with and subject to the rules specified in the Section 125 Plan. Notwithstanding the foregoing, changes in coverage and changes in the cost of coverage will not serve as a basis for a change in election under this Health FSA Plan.

There is no limit to the number of Qualifying Changes in Status that can occur during a Plan Year.

The Plan Administrator shall make all determinations, in its sole discretion and on a uniform and consistent basis, as to whether a Qualifying Change in Status has occurred and whether a requested election change under this Health FSA Plan is consistent with a Qualifying Change in Status. For purposes of making such a determination, the Plan Administrator may require an Eligible Employee to submit evidence that the Eligible Employee has incurred a Qualifying Change in Status and such other evidence as the Plan Administrator deems reasonable under the circumstances.

(d) Special Enrollment Rules

An Eligible Employee may elect to enroll in coverage under this Health FSA Plan when a Special Enrollment Event occurs in accordance with the rules specified under the Section 125 Plan.

2.03 Default Coverage

In the event of a failure to elect coverage, the following rules shall apply:

(a) If a newly Eligible Employee fails to properly complete the Enrollment Process by the date specified in Section 2.02(a), the Eligible Employee shall be deemed to waive coverage under the Health FSA Plan for the balance of the Plan Year.

(b) If an Eligible Employee fails to properly complete the Enrollment Process or to elect coverage under this Health FSA Plan by the end of the Annual Enrollment Period for a Plan Year, the Eligible Employee shall be deemed to waive coverage under this Health FSA Plan for that Plan Year.

In either case (a) or (b), the Eligible Employee shall be permitted to enroll in coverage in accordance with Section 2.02(b) during the next Annual Enrollment Period or in accordance with Section 2.02(c) following a Qualifying Change in Status event.

For all purposes under the Health FSA Plan, any default treatment with respect to the Health FSA Plan triggered by this Section 2.03 shall be treated as if it had been affirmatively elected by an Eligible Employee.

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ARTICLE III

TERMINATION OFBENEFITS

3.01 Termination Date of Coverage

A Participant shall cease participation in the Health FSA Plan as set forth in the Section 125 Plan.

An individual whose participation in the Health FSA Plan ceases under this Section, other than a Qualified Beneficiary who continues coverage pursuant to an election under Section 3.04, shall continue to be entitled to reimbursements under the Health FSA Plan for Health Care Expenses incurred prior to the date of such cessation in an amount that does not exceed the lesser of: (i) the individual's Health Care Expenses Incurred during the portion of such Plan Year in which he is a Participant; or (ii) the annual amount elected under the Section 125 Plan for the reimbursement of Health Care Expenses (less reimbursable Health Care Expenses that were Incurred in the Plan Year while the individual was a Participant, and that have previously been reimbursed), subject to any limitations on reimbursement otherwise discussed herein.

3.02 Coverage While on Family and Medical Leave

An Eligible Employee may participate in the Health FSA Plan during a period of family or medical leave of absence from the University in accordance with and only to the extent provided under the University's policy and as required by the FMLA, or other applicable law, as set forth in the Section 125 Plan. The Eligible Employee shall be required to pay for such coverage before, during or after the leave in accordance with such rules as the University may prescribe.

3.03 Coverage Following Severance

Participation in the Health FSA Plan shall be continued during a period for which the individual is entitled to severance benefits from the University to the extent and only to the extent the individual is entitled to coverage during such period.

3.04 Continuation Coverage Under COBRA

Qualified Beneficiaries shall be entitled to elect COBRA continue coverage under this Health FSA Plan in accordance with the rules set forth in COBRA, the regulations promulgated thereunder, and any notices or other communications furnished by the University. Such coverage shall be provided only as required under COBRA, and such coverage shall cease as soon as, and the premiums shall be as great as, permitted by applicable law and the regulations promulgated thereunder.

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ARTICLE IV

BENEFITS, FUNDING, AND CONTRIBUTIONS

4.01 Provision of Benefits

The benefits available under this Health FSA Plan for a Plan Year shall take the form of reimbursement for Health Care Expenses Incurred during the Plan Year. A Participant shall be entitled to reimbursement under this Health FSA Plan only for Health Care Expenses Incurred after his participation has commenced and before his participation has ceased.

4.02 Amount of Reimbursement

Except as provided under Section 3.01, at all times during the Plan Year, a Participant shall be entitled to reimbursement under this Health FSA Plan in an amount that does not exceed the anticipated amount to be allocated on his behalf under the Section 125 Plan (or under his election as a Qualified Beneficiary under Section 3.04) for payment of Health Care Expenses under the Health FSA Plan (less any previously reimbursed Health Care Expenses during the Plan Year), regardless of the actual amount then standing to the Participant's credit under the Section 125 Plan for payment of Health Care Expenses under the Health FSA Plan. Each payment hereunder shall be a charge against the amount available to pay Health Care Expenses under the Health FSA Plan. Notwithstanding the preceding, no reimbursements are available for Health Care Expenses incurred after the Participant has ceased to participate in the Health FSA Plan, unless the Participant has elected COBRA continuation coverage.

4.03 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Health FSA Plan to the contrary, the Participant's reimbursement under this Health FSA Plan for any Plan Year shall be limited to the smallest of the following:

(a) the Participant's Health Care Expenses Incurred during the Plan Year;

(b) the amount elected by the Participant for the payment of Health Care Expenses under the Plan for the Plan Year (less any reimbursed Health Care Expenses); or

(c) the annual maximum amount described in Section 4.04; or

(d) any limitation established with respect to the Participant pursuant to Section 4.04.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year. To the extent the amount of contributions credited to a Participant's account for a Plan Year pursuant to his compensation reduction

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agreement and election of coverage under this Health FSA Plan exceeds his Health Care Expenses appropriately submitted for reimbursement for a Plan Year, the amounts credited to his account shall be forfeited and applied toward administrative expenses under the Health FSA Plan.

Claims for expenses incurred prior to a Participant's termination date must be submitted within 90 days of termination.

Under no circumstances will future or projected Health Care Expenses be reimbursed in advance, nor will expenses incurred prior to a Plan Year be reimbursed.

4.04 Annual Limits

The annual maximum amount that a Participant may allocate for the reimbursement of Health Care Expenses under the Health FSA Plan for any Plan Year shall be the maximum amount that the University shall prescribe and communicate to Participants, subject to the limitation set forth in Section 125(i) of the Code. The minimum amount that a Participant may allocate for the reimbursement of Health Care Expenses under the Health FSA Plan for any Plan Year shall be $120.00 or such other amount that the University shall prescribe and communicate to Participants.

4.05 Grace Period

Any amount remaining in a Participant's Health FSA Account is forfeited by the Participant if a claim has not been filed by the applicable run-out period (established by the Plan Administrator) following the last day of the Plan Year. Notwithstanding the foregoing, the Plan Administrator has established a Grace Period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Health Care Expenses Incurred during the Grace Period.

4.06 Expense Reimbursement Procedure

Reimbursement of Health Care Expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Health Care Expenses under this Health FSA Plan, a Participant must submit a request for reimbursement to the Claim Administrator not later than April 30 of the Plan Year following the Plan Year (and applicable Grace Period) in which such Health Care Expenses were Incurred and in accordance with such rules as the Claim Administrator may specify.

(b) Reimbursement for Health Care Expenses under the Health FSA Plan may be made by electronic debit card at the time the Expense is Incurred in accordance with such rules as the Claim Administrator may specify, in its discretion. The Claim Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement.

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Each request for reimbursement shall include such substantiation as required by the Claim Administrator, which may include the following information:

(i) the name, Social Security number, and address of the employee;

(ii) the name and date of birth of the person for whom the Health Care Expense was Incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;

(iii) the name and address of the person, organization or other provider to whom the Health Care Expense was or is to be paid;

(iv) a written statement from an independent third party setting forth the type, purpose, date and amount of the Health Care Expense for which reimbursement is requested; and

(v) a statement that the Participant has not been reimbursed nor is reimbursable for the Health Care Expense by insurance or otherwise, and that the Participant has not been allowed a deduction for such Health Care Expense under section 213 of the Code.

The Claim Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the above described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Plan. The Claim Administrator may require the Participant to provide written authorization to obtain information from any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his Dependents are enrolled.

(c) Subject to applicable law, the University may establish such rules as it deems desirable regarding the frequency of reimbursement of Health Care Expenses and the minimum dollar amount that may be requested for reimbursement.

4.07 Contributions and Funding

Reimbursements for Health Care Expenses for any given Plan Year shall be financed out of contributions made by the University pursuant to Participants' compensation reduction agreements under the Section 125 Plan and, to the extent such amounts, held in the Employee's Health FSA Plan account, are insufficient to make the reimbursement, out of other general assets of the University. Subject to applicable nondiscrimination requirements, each Participant's Health FSA Plan account shall be credited with the portion of the Participant's Compensation Reduction Amounts for that Plan Year that the

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Participant elects to apply toward the Health FSA Plan and any contributions allocated thereto by the University, as applicable. All payments shall be made from the general assets of the University, and no assets shall be earmarked or segregated for purposes of providing benefits. The University may establish rules in addition to those already prescribed hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis. Any amounts remaining in a Participant's account after the end of the period for submitting reimbursements may be retained by the University and used to offset administrative expenses.

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ARTICLE V

PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to payment of any benefits from a Participant's Health FSA Plan account, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, the completion and filing of an application and the provision of information, as described in Section 4.06. The Participant must also furnish any pertinent information requested by the Claim Administrator and give the Claim Administrator written authorization to obtain information from any group medical, HMO, dental, vision care, prescription drug, or other health plans in which Participant or his Dependents are enrolled. Application for reimbursement must be furnished by April 30 of the Plan Year following the Plan Year in which the claim is Incurred.

5.02 Assignment of Benefits

Except to the extent provided in this Health FSA Plan, no benefit payable at any time under this Health FSA Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Health FSA Plan, the Plan Administrator, the Claim Administrator, and the University.

5.03 Payment to Representative

In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under this Health FSA Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Health FSA Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Health FSA Plan and the obligations of the Plan Administrator, the Claim Administrator, and the University.

5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Health Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Health Care Expense shall completely discharge all liability of this Health FSA Plan, the Claim Administrator, the Plan Administrator, and the University with respect to such expense.

5.05 Overpayments

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If, for any reason, a Participant is reimbursed for expenses that are not Health Care Expenses or that are not substantiated in accordance with the Plan Administrator's procedures, as applicable, or a Participant otherwise receives any benefit under this Health FSA Plan that is erroneously paid or exceeds the amount payable on account of a Participant's Health Care Expenses, the Participant shall be responsible for refunding the overpayment to the Health FSA Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Health FSA Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

5.06 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Claim Administrator, the Plan Administrator, and the University shall have no obligation or duty to locate a Participant. In the event a Participant becomes entitled to payment under this Health FSA Plan and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of the Health FSA Plan without any consideration to interest payments which may have accrued.

5.07 Missing Person

If, within seven (7) years after any amount becomes payable under this Health FSA Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the University and shall cease to be a liability of this Health FSA Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

5.08 Fraudulent Claims

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Health FSA Plan, the Plan Administrator may without anyone's consent terminate coverage, and the Claim Administrator may refuse to honor any claim under the Health FSA Plan.

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ARTICLE VI

ADMINISTRATION OF THE PLAN

6.01 Administration

The Health FSA Plan, including claims arising hereunder, including amending and terminating the Health FSA Plan, shall be administered in accordance with Articles VI, VII, and VIII of the Section 125 Plan.

6.02 Claims Procedure

The Claim Administrator shall review claims for benefits under this Health FSA Plan and respond thereto within 90 days after receiving the claim. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification setting forth:

(a) the specific reason or reasons for the denial;

(b) specific reference to pertinent Health FSA Plan provisions upon which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim;

(d) if an internal rule, guideline or protocol was relied upon in making the determination, a copy of the rule, guideline or protocol or a statement that it will be provided free of charge upon request; and

(e) an explanation of the claim review procedure set forth below.

The claimant or the claimant's duly authorized representative may request a full and fair review of the claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator.

The review of a claim by the Plan Administrator shall be subject to the following rules. The claimant or the claimant's duly authorized representative may review pertinent documents and may submit issues and comments, including without limitation appropriate evidence or testimony of an expert, in writing. The review will not afford deference to the initial adverse benefit determination. The review will not be conducted by the individual who made the adverse benefit determination or by that individual's subordinate. The Plan Administrator shall make a decision promptly, and not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in

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writing and shall include specific reasons for the decision, and specific references to the pertinent Plan provisions on which the decision is based.

In the event that the Claim Administrator or Plan Administrator does not make a determination with respect to a claim within the time limit prescribed by this Section, the claim or appeal of such claim decision shall be deemed denied.

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Schedule B

University of Delaware
Dependent Care Flexible Spending Account
Plan Amended and Restated effective January 1, 2020

INTRODUCTION

The University of Delaware maintains the University of Delaware Dependent Care Flexible Spending Account Plan (the "Dependent Care FSA Plan") to provide for the reimbursement of certain dependent care assistance expenses to its eligible employees. This document sets forth the provisions, which, together with the Appendices hereto and the materials, if any, incorporated by reference herein or in any of the Appendices, constitute the Dependent Care FSA Plan, as amended and restated effective July 1, 2025 and for purposes of the Code, this Schedule B constitutes a separate written plan providing for the reimbursement of certain expenses related to dependent care assistance.

This Dependent Care FSA Plan provides solely for the reimbursement of certain dependent care assistance expenses.

This Dependent Care FSA Plan is intended to qualify as a "dependent care assistance program" within the meaning of section 129(d) of the Code and any other pertinent laws or regulations, so that the benefits provided under the Dependent Care FSA Plan shall be eligible for exclusion from each Employee's income for federal income tax purposes under section 129(a) of the Code. The provisions of this Dependent Care FSA Plan shall be interpreted in accordance with that intent.

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ARTICLE I

DEFINITIONS

As used in this Schedule B, the following terms have the meanings set forth below. Other capitalized terms used herein that are not defined below are defined in the Section 125 Plan.

Annual Enrollment Period

Annual Enrollment Period means the period of time preceding the beginning of each Plan Year, designated by the Plan Administrator, during which Eligible Employees may elect to participate in the Dependent Care FSA Plan and elect a Compensation Reduction Amount to contribute to the Dependent Care FSA Plan.

Dependent

Dependent means any individual who is a dependent of a Participant within the meaning of Section 152 of the Code.

Dependent Care Center

Dependent Care Center means any facility which:

(a) provides care for more than six individuals (other than individuals who reside at the facility); and

(b) receives a fee, payment or grant for service for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

Dependent Care Deposits

Dependent Care Deposits means the amount credited, as a bookkeeping entry only, to a Participant's Dependent Care FSA account under the Section 125 Plan, to provide reimbursement for Dependent Care Expenses hereunder.

Dependent Care Expense

Dependent Care Expense means any reasonable expense Incurred by the Participant or his Spouse for Qualifying Services, provided that no expenses for services provided at a Dependent Care Center shall be considered a Dependent Care Expense unless the services are provided by a Qualifying Dependent Care Center. The Claim Administrator shall determine, in its sole discretion and on a uniform and consistent basis, whether any expense is reasonable. An expense is a Dependent Care Expense only if it is paid to a person who is not:

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(a) a Dependent of the Participant;

(b) the Participant's Spouse; or

(c) a child of the Participant under age 19.

Dependent Care FSA Plan

Dependent Care FSA Plan means The University of Delaware Dependent Care Flexible Spending Account Plan, as described in this Schedule B, and as may be amended from time to time.

Earned Income

Earned Income means Earned Income within the meaning of Section 32(c)(2) of the Code, excluding amounts paid by the University for dependent care assistance to any Employee.

Educational Institution

Educational Institution means any educational organization, the primary function of which is the presentation of formal instruction and which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

Grace Period

Grace Period means the period beginning on the first day following the last day of the Plan Year and ending on the 15th day of the third month following the last day of the Plan Year.

Household

Household means, solely for purposes of determining who is a "Spouse," the collection of persons sharing a common abode with the Participant as part of a single family unit, including those related by blood, marriage or adoption, and others who live as part of the family unit, including children away from the common abode regularly attending school on a full-time basis.

Incurred

Incurred means provided with dependent care assistance services, giving rise to the claimed expense, not when the expense is formally billed, charged, or paid.

Participant

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Participant means any Eligible Employee who meets the requirements for participation under this Dependent Care FSA Plan and for whom coverage is in effect under this Dependent Care FSA Plan.

Plan Year

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

Qualifying Change in Status

Qualifying Change in Status means a Qualifying Change in Status within the meaning of the Section 125 Plan.

Qualifying Dependent

Qualifying Dependent means, with respect to any Participant, an individual who is a "qualifying individual" under the Code. A qualifying individual for this purposes is an individual who is either (1) a tax dependent of the Participant as defined in Section 152 of the Code who is under the age of 13 and who is the Participant's qualifying child as defined in Section 152(c)(1) of the Code; (2) a tax dependent of the Participant as defined in Section 152 of the Code, determined without regard to Sections 152(b)(1), 152(b)(2) and 152(d)(1)(B) of the Code, 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 (3) 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.

Qualifying Dependent Care Center

Qualifying Dependent Care Center means a Dependent Care Center which complies with all applicable state and local laws and regulations.

Qualifying Services

Qualifying Services means Services performed:

(a) in the home of the Participant; or

(b) outside the home of the Participant for:

(i) the care of a Qualifying Dependent of the Participant under age 13 (or, as applicable, age 14); or

(ii) the care of any other Qualifying Dependent who spends at least eight hours a day in the Participant's home; provided that no such services at an overnight

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camp shall be Qualifying Services.

If the expenses are incurred for services provided by a Dependent Care Center, the center must be a Qualifying Dependent Care Center.

Section 125 Plan

Section 125 Plan means the University of Delaware Section 125 Plan to which this Dependent Care FSA is a schedule, as amended from time to time and any other plan sponsored by the University which is intended to comply with Section 125 of the Code and with respect to which is a qualified benefit within the meaning of Section 125(f) of the Code.

Services

Services means household services or other services related to the care of a Qualifying Dependent that are performed to enable a Participant or his Spouse to remain or become gainfully employed.

Spouse

Spouse means the spouse of a Participant, but shall not include:

(a) an individual legally separated from a Participant under a decree of divorce or separate maintenance; or

(b) an individual who is married to the Participant, but

(i) files a separate income tax return;

(ii) maintains as his home a Household which constitutes for more than one half of the taxable year the principal place of abode of a Qualifying Dependent, but of which the Participant is not a member during the last six months of such taxable year; and

(iii)furnishes over one-half of the cost of maintaining such Household during the taxable year.

Student

Student means an individual who during each of five calendar months during a Plan Year is a full-time student at an Educational Institution.

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ARTICLE II

ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

An Eligible Employee shall be eligible to participate in this Dependent Care FSA Plan as of the date the Eligible Employee is eligible to participate in the Section 125 Plan.

2.02 Enrollment

Except to the extent provided in Section 2.03, an Eligible Employee must enroll in coverage to become a Participant in the Dependent Care FSA Plan. An Eligible Employee may elect, waive, or change coverage under this Dependent Care FSA Plan in accordance with and only in accordance with the provisions of this Section.

(a) Initial Enrollment

An individual who is newly eligible to participate in the Dependent Care FSA Plan must properly complete the Enrollment Process to enroll in the Dependent Care FSA Plan and commence participation in the Dependent Care FSA Plan. The Enrollment Process must be completed no later than 30 days after becoming eligible.

If the Eligible Employee does not properly complete the Enrollment Process by the applicable time period, the Eligible Employee shall not be covered under the Dependent Care FSA Plan.

(b) Annual Enrollment Period

Each Eligible Employee who is a Participant in the Dependent Care FSA Plan or who is eligible to become a Participant in the Dependent Care FSA Plan shall be notified, prior to each Plan Year, of his right to become a Participant in the Dependent Care FSA Plan, to continue participation in the Dependent Care FSA Plan or to modify or to cease participation in the Dependent Care FSA Plan and shall be given a reasonable period of time in which to exercise such right. Such reasonable period of time shall be known as the "Annual Enrollment Period." During the Annual Enrollment Period, an Eligible Employee may enroll for, waive, or modify the rate of his contributions by properly completing the Enrollment Process. Such new election shall be effective on the January 1 following the Annual Enrollment Period. If an individual does not properly complete the Enrollment Process by the end of the Annual Enrollment Period, the Eligible Employee shall not be covered under the Dependent Care FSA Plan.

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(c) Mid-Year Changes

Subject to the following rules, an Eligible Employee shall be permitted to change coverage under this Dependent Care FSA Plan during the Plan Year in accordance with the rules specified in the Section 125 Plan:

(1) A change in the number of an Eligible Employee's Qualifying Dependents, and not a change in the number of the Eligible Employee's Dependents, shall be treated as a Qualifying Change in Status; and

(2) A significant increase in the cost of a dependent care provider shall be adjusted as a significant increase in the cost of a Benefit Option if and only if the provider is not a relative of the Eligible Employee.

2.03 Default Coverage

In the event of a failure to elect coverage, the following rules shall apply:

(a) If a newly Eligible Employee fails to properly complete the Enrollment Process by the date specified in Section 2.02(a), the Eligible Employee shall be deemed to waive coverage under the Dependent Care FSA Plan for the balance of the Plan Year.

(b) If an Eligible Employee fails to properly complete the Enrollment Process or to elect coverage under this Dependent Care FSA Plan by the end of the Annual Enrollment Period for a Plan Year the Eligible Employee shall be deemed to waive coverage under this Dependent Care FSA Plan for that Plan Year.

In either case (a) or (b), the Eligible Employee shall be permitted to enroll in coverage in accordance with Section 2.02(b) during the next Annual Enrollment Period or in accordance with 2.02(c) following a Qualifying Change in Status.

For all purposes under the Dependent Care FSA Plan, any default treatment with respect to the Dependent Care FSA Plan triggered by this Section 2.03 shall be treated as if it had been affirmatively elected by an Eligible Employee.

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ARTICLE III

TERMINATION OF BENEFITS

3.01 Termination Date of Employee's Coverage

A Participant shall cease participation in the Dependent Care FSA Plan as set forth in the Section 125 Plan, provided that for any Plan Year, a former Participant shall continue to be entitled to reimbursements under the Dependent Care FSA Plan for Dependent Care Expenses in an amount that does not exceed the lesser of: (i) the former Participant's Dependent Care Expenses Incurred during the portion of such Dependent Care FSA Plan Year in which he is a Participant; or (ii) the amount credited under the Section 125 Plan for the reimbursement of Dependent Care Expenses as of the date the individual ceases to be a Participant (less reimbursable Dependent Care Expenses that were Incurred in the Plan Year while the individual was a Participant and that have previously been reimbursed), subject to any limitations on reimbursement otherwise discussed herein.

3.02 Coverage While on Family and Medical Leave

An Eligible Employee may participate in the Dependent Care FSA Plan during a period of family or medical leave of absence from the University in accordance with and only to the extent provided under the University's policy and as required by the FMLA, or other applicable law, as set forth in the Section 125 Plan. The Eligible Employee shall be required to pay for such coverage before, during or after the leave in accordance with such rules as the University may prescribe.

3.03 Coverage Following Severance

Participation in the Dependent Care FSA shall be continued during a period for which the individual is entitled to severance benefits from the University to the extent and only to the extent the individual is entitled to coverage under this Dependent Care FSA Plan.

3.04 Leaves of Absence

An Eligible Employee who takes a leave of absence, other than a leave of absence described in Section 3.02, from the University shall continue to be an Eligible Employee to the extent and only to the extent provided in the personnel policies and practices of the University or elsewhere in this Dependent Care FSA Plan.

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ARTICLE IV

BENEFITS, FUNDING, AND CONTRIBUTIONS

4.01 Provision of Benefits

The benefits available under this Dependent Care FSA Plan for a Plan Year shall take the form of reimbursement for Dependent Care Expenses Incurred during the Plan Year. A Participant shall be entitled to reimbursement under this Dependent Care FSA Plan only for Dependent Care Expenses Incurred after his participation has commenced and before his participation has ceased.

4.02 Amount of Reimbursement

Reimbursement shall be made for Dependent Care Expenses Incurred in a Plan Year only to the extent such Dependent Care Expenses do not exceed Dependent Care Deposits made and not previously expended for that Plan Year. No reimbursement or payment of Dependent Care Expenses Incurred during the Plan Year will at any time exceed the balance of the Dependent Care FSA Plan account for the Plan Year at the time of the reimbursement or payment. To the extent Dependent Care Expenses claimed exceed the existing balance of Dependent Care Deposits for a Plan Year, such expenses shall be held in suspense until Dependent Care Deposits for the Plan Year are available. Each payment made under this Dependent Care FSA Plan shall be a charge against the amount available to pay Dependent Care Expenses under the Dependent Care FSA Plan.

4.03 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Dependent Care FSA Plan to the contrary, the Participant's reimbursement under this Dependent Care FSA Plan shall be limited to the smallest amount resulting from the following:

(a) the Participant's Dependent Care Expenses Incurred during the Plan Year;

(b) the Participant's Dependent Care Deposits for the Plan Year, less any reimbursed Dependent Care Expenses;

(c) the annual maximum amount described in Section 4.04;

(d) where applicable, the Earned Income limitation described in Section 4.05; or

(e) any limitation established with respect to the Participant pursuant to Section 4.04.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year. To the extent that a Participant's Dependent Care Deposits for a Plan Year exceed his Dependent Care Expenses that are

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appropriately submitted for reimbursement for such Plan Year, the Deposits shall be forfeited and applied toward administrative expenses under the Dependent Care FSA Plan. Claims for expenses incurred prior to a Participant's termination date must be submitted for reimbursement within 90 days of termination.

Under no circumstances will future or projected expenses be reimbursed in advance, nor will expenses Incurred prior to a Plan Year be reimbursed.

4.04 Annual Limits

A Participant's Dependent Care Deposits and reimbursements for a taxable year shall not exceed the annual maximum set forth in section 129(a)(2) of the Code, which as of the Effective Date is as follows:

(a) $5,000 if the Participant is single or if the Participant is married and filing a joint federal income tax return with his Spouse;

(b) $2,500 if the Participant is married and filing a separate income tax return from his Spouse.

The minimum amount that a Participant may allocate as Dependent Care Deposits for a taxable year shall not be less than $120.00.

4.05 Grace Period

Any amount remaining in a Participant's Dependent Care FSA Plan account is forfeited by the Participant if a claim has not been filed by the applicable run-out period (established by the Plan Administrator) following the last day of the Plan Year. Notwithstanding the foregoing, the Plan Administrator has established a Grace Period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Dependent Care Expenses incurred during the Grace Period.

4.06 Earned Income Limitation

A Participant may not receive reimbursement for Dependent Care Expenses in any taxable year in excess of the lesser of:

(a) his Earned Income for such taxable year; or

(b) if married at the close of the taxable year, the Earned Income of his Spouse for such taxable year.

For purposes of this Section 4.06, a Spouse of a Participant who is not employed during any month of any taxable year in which the Participant has Incurred Dependent Care Expenses, and in which the Spouse is either a Student or physically or mentally incapable of caring for himself, shall be deemed to have Earned Income for such month in an amount

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equal to: (i) $250, if there is one Qualifying Dependent for whom the Participant has Incurred Dependent Care Expenses during such taxable year; or (ii) $500, if there is more than one Qualifying Dependent for whom the Participant has Incurred Dependent Care Expenses during such taxable year.

4.07 Expense Reimbursement Procedure

Reimbursement of Dependent Care Expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Dependent Care Expenses under this Dependent Care FSA Plan, a Participant must submit a request for reimbursement to the Claim Administrator[4] not later than April 30 of the Plan Year following the Plan Year (and applicable Grace Period) in which such Dependent Care Expenses were Incurred and in accordance with such rules as the Claim Administrator may specify, in its sole discretion.

(b) The Claim Administrator reserves the right to verify to its satisfaction all claimed Dependent Care Expenses prior to reimbursement. Each request for reimbursement shall include such substantiation as required by the Claim Administrator, which may include the following information:

(1) the name, Social Security number, and address of the Qualifying Dependent for whom Services are provided;

(2) the nature and dates of the Services and amount of Dependent Care Expenses;

(3) the relationship, if any, of and other information regarding the person performing the Services to the Participant;

(4) if the Services are performed for a child of the Participant, the age of the child;

(5) a statement as to where the Services are performed;

The Claim Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence or certification of payment or of obligation to pay Dependent Care Expenses. The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the above described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Dependent Care FSA Plan.

(c) The University may establish such rules as it deems desirable regarding the

[4] Note to UD: This is not defined.

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frequency of reimbursement of Dependent Care Expenses and the minimum dollar amount that may be requested for reimbursement.

4.08 Contributions and Funding

Reimbursements for Dependent Care Expenses for any given Plan Year shall be financed out of contributions made by the University pursuant to Participants' compensation reduction agreements under the Section 125 Plan. Subject to applicable nondiscrimination requirements, each Participant's Dependent Care FSA account shall be credited with such Participant's Dependent Care Deposits, as applicable. All payments shall be made from the general assets of the University, and no assets shall be earmarked or segregated for purposes of providing benefits. The University may establish rules, in addition to those hereunder, for minimum and maximum contributions that may be made on an annual, monthly, payroll period, or other basis.

Any amounts remaining in a Participant's account after the end of the period for submitting reimbursements may be retained by the University and used to offset administrative expenses.

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ARTICLE V

PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to payment of any benefits from a Participant's Dependent Care FSA Plan account, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, completion and filing of an application and the provision of information, as described in Section 4.07.

5.02 Assignment of Benefits

Except to the extent provided in this Dependent Care FSA Plan, no benefit payable at any time under this Dependent Care FSA Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Dependent Care FSA Plan, the Plan Administrator, the Claim Administrator, and the University.

5.03 Payment to Representative

In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under this Dependent Care FSA Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Dependent Care FSA Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Dependent Care FSA Plan and the obligations of the Plan Administrator, the Claim Administrator, and the University.

5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Dependent Care Expenses. Any benefit payment made directly to a Participant or a Participant's representative (as described in Section 5.03) for a Dependent Care Expense shall completely discharge all liability of this Dependent Care FSA Plan, the Claim Administrator, the Plan Administrator, and the University.

5.05 Overpayments

If, for any reason, a Participant is reimbursed for expenses that are not Dependent Care Expenses or that are no substantiated in accordance with the Plan Administrator's procedures, as applicable, or a Participant otherwise receives any benefit under this

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Dependent Care FSA Plan that is erroneously paid or exceeds the amount payable on account of a Participant's Dependent Care Expenses, the Participant shall be responsible for refunding the overpayment to the Dependent Care FSA Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Dependent Care FSA Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

5.06 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Claim Administrator, the Plan Administrator and the University shall have no obligation or duty to locate a Participant. In the event a Participant becomes entitled to payment under this Dependent Care FSA Plan and such payment cannot be made for any reason the amount of such payment, if and when made, shall be determined under the provisions of the Dependent Care FSA Plan without any consideration to interest payments which may have accrued.

5.07 Missing Person

If, within seven (7) years after any amount becomes payable under this Dependent Care FSA Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the University and shall cease to be a liability of this Dependent Care FSA Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

5.08 Fraudulent Claims

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Dependent Care FSA Plan, the Plan Administrator may without anyone's consent terminate coverage, and the Claim Administrator may refuse to honor any claim under the Dependent Care FSA Plan.

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ARTICLE VI

ADMINISTRATION OF THE PLAN

6.01 Administration

The Dependent Care FSA Plan, including any claims arising hereunder, including amending and terminating the Dependent Care FSA Plan shall be administered in accordance with Articles VI, VII and VIII of the Section 125 Plan.

6.02 Claims Procedure

The Claim Administrator shall review claims for benefits under this Dependent Care FSA Plan and respond thereto within a reasonable period after receiving the claim. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification of such denial. If a claim is denied, the claimant shall have a reasonable period to appeal the denial to the Plan Administrator.

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