FURMAN UNIVERSITY

SECTION 125 CAFETERIA PLAN

AND

FURMAN UNIVERSITY

FLEXIBLE SPENDING ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

AS RESTATED AND EFFECTIVE

JANUARY 1, 2017

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INTRODUCTION

Furman University (the "Employer") has established the Furman University Section 125 Cafeteria Plan ("Cafeteria Component") and Furman University Flexible Spending Account Plan ("FSA Component") (collectively, the "Plan") for all eligible employees. This type of plan is sometimes called a "cafeteria" plan because it allows you choose from several different insurance and benefit programs according to your individual needs. The benefits you may choose are outlined in this Summary Plan Description ("SPD"). We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before income and Social Security taxes are withheld. This means that you may pay less tax and have more money to spend and save.

Read this SPD carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Plan Administrator. There is a Plan document on file that you may review if you desire. In the event there is a conflict between this SPD and the Plan document, the Plan document will control. Also, if there is a conflict between an insurance contract or other employee benefit plan document and either the Plan document or this Summary Plan Description, the insurance contract or other employee benefit plan document will control.

ELIGIBILITY AND ENROLLMENT

A. When Can I Become A Participant In The Plan?

Before you can become a "participant" in the Plan, there are certain rules that you must satisfy. First you must meet the eligibility requirements, then you must fill out and submit the appropriate paperwork (called the "election forms"), then you must wait until your entry date, described below.

B. What Are The Eligibility Requirements For Our Plan?

You are eligible to participate in the Plan's Cafeteria Component if you receive benefits pursuant to one or more of the following benefits and pay part or all of the cost for such benefits:

- Medical Reimbursement Account Benefits
- Dependent Care Reimbursement Account Benefits
- Medical Insurance (pre-tax contributions for Employees' cost of coverage)
- Dental Insurance (pre-tax contributions for Employees' cost of coverage)
- Vision Insurance (pre-tax contributions for Employees' cost of coverage)
- Health Savings Account (Employee and/or Employer pre-tax contributions)

You are eligible to participate in this Plan's Cafeteria Component as of the date coinciding with your eligibility for a benefit described above. To be eligible to participate in the Medical Reimbursement Account Benefit and the Dependent Care Reimbursement Account Benefit, you must also satisfy the eligibility requirements described below for the FSA Component.

You are eligible to participate in the Plan's FSA Component if you normally perform services for the Employer of at least 30 hours per week for at least 39 weeks per year. Any Employee whose employment begins after the beginning of the Plan Year may begin participation on the first day of the month following the date of hire.

To be eligible to participate in the Plan, you must also be an employee of the Employer. Leased employees, independent contractors, and temporary employees are not eligible to participate in the Plan.

C. When Do I Fill Out Election Forms?

You may enroll in the Plan when you are first eligible to participate. Benefits become effective on the first day of the month following your date of hire. If your date of hire is on the first day of the month, benefits are effective on the first day of the same month in which you were hired. After you first become eligible, you have 30 days to enroll. If you do not enroll during that 30-day period, you generally will have to wait until the next open enrollment period. You may also be able to enroll during the plan year if you experience a change in status that would make participation in the Plan appropriate for you. Your completed election forms must be submitted to the Plan Administrator. You will generally need to re-enroll in the Plan during each open enrollment period following your initial enrollment. The open enrollment period is usually within the first two weeks of November.

On the election form, you will choose one or more of the benefits available under the Plan (these are called your "benefit elections"), as well as agree to a salary redirection to pay for the benefits you elected. You will be provided with election forms by the Plan Administrator.

D. What Is My Entry Date?

If your date of hire is on the first day of the month, benefits are effective on the first day of the same month in which you were hired, provided you are eligible to participate in the Plan and

have submitted your election forms within the enrollment period. Your entry date will also be the first day of the month you were hired.

If your date of hire is not the first day of the month, benefits are effective on the first day of the month following your date of hire, provided you are eligible to participate and have submitted your election forms within the enrollment period. Your entry date will also be the first day of the month following the month in which you were hired.

E. When Does My Participation Terminate?

Your participation in this Plan terminates on (a) your termination of employment for any reason, (b) the date on which you are no longer eligible for benefits hereunder, or (c) the termination of this Plan.

F. What If I Am Rehired By The Employer?

If your coverage under the Plan is terminated because of your termination of employment, and you are rehired during the same plan year and within 30 days of the termination of employment, you may be permitted to resume participation in the Plan, provided that any enrollment form or salary reduction agreement in effect prior to your termination of employment is reinstated, and provided that you may again begin participation in the applicable benefit program. Notwithstanding the preceding sentence, if an event has occurred after termination and prior to rehire that would otherwise permit a change in election, you may be permitted to change the prior election accordingly. If you are rehired more than 30 days following your immediately preceding termination of employment, you will be treated as a new Employee for purposes of your elections under this Plan. Notwithstanding any of the foregoing, an election to participate in the insurance premium payment benefit will be reinstated only to the extent that coverage under the Employer's medical, dental, and/or vision plan is reinstated. Likewise, the HSA benefit election will be reinstated only if an individual is eligible to contribute to an HSA and enrolled in a high deductible health plan ("HDHP") sponsored by the Employer.

BENEFITS

A. What Benefits Are Available For My Accounts?

Under our Plan, you can choose to elect to pay for one or more of the following benefits or expenses during the plan year on a pre-tax basis:

Medical, Dental, and/or Vision Premiums and Contributions

You may use the Plan to pay for premiums or contributions for medical, dental, and/or vision plan coverage offered by the Employer during the plan year.

If you are a low-income family, there may be a health insurance tax credit available on your federal tax return if you purchase health insurance for a dependent. If you choose to utilize this Plan for your health insurance premiums, you cannot use the tax credit for those premiums.

Health Savings Account ("HSA") Contributions

If you are enrolled in an HDHP sponsored by the Employer, you may use the Plan to contribute to an HSA on a pre-tax basis. Federal law establishes the requirements to be eligible to contribute to an HSA, and you must meet those requirements to make HSA contributions. You are solely responsible for determining whether you are eligible to contribute to an HSA.

The HSA is not an ERISA employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Benefits consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis under the Plan. The HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by you, as the participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pre-tax salary reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax salary-reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. Neither your HSA nor the HSA component of this Plan that allows you to contribute to your HSA on a pre-tax basis is subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Medical Expense Reimbursement

Reimbursement is available for any qualified medical expense (other than health, dental, or vision insurance premiums) which (a) is a prescription medication, insulin, or would be allowable as a deduction for medical expenses on your federal income tax return and (b) is not reimbursable from any other source. Examples of such expenses include deductibles and copays, prescription drugs, and eyeglasses. If you use the Plan to pay for a medical expense, that same expense cannot be itemized on your federal income tax return.

A statement must accompany claims for reimbursement from the service provider indicating the name of the recipient and the date and a description of the services provided.

The Plan includes two options for the Medical Expense Reimbursement benefit: the General Purpose Medical Reimbursement Account and the Limited (Vision/Dental) Medical Reimbursement Account option. Participants who are covered by an HDHP may not elect the General Purpose Medical Reimbursement Account benefit. Such Employees may elect only the Limited (Vision/Dental) Medical Reimbursement Account option. A participant who elects the HDHP option for a plan year beginning on or after January 1, 2017 is treated as automatically enrolled in the Limited (Vision/Dental) Medical Reimbursement Account option for that plan year. For purposes of the Limited (Vision/Dental) Medical Reimbursement Account option, Medical Expenses means expenses incurred by a participant or his or her Spouse or Dependents for medical

care as defined in Code § 213(d) and as further described in the Plan; provided, however, that such expenses are for vision care or dental care (as defined in Code § 223(c)) only.

If you elect the HDHP option for a plan year beginning on or after January 1, 2017, you are treated as automatically enrolled in the Limited (Vision/Dental) Medical Reimbursement Account option for that plan year, and unused amounts remaining in your General Purpose Medical Reimbursement Account at the end of the preceding plan year that are available for carryover, if any, will be automatically carried over to the Limited (Vision/Dental) Medical Reimbursement Account option. However, you may continue to submit claims for general purpose medical expenses incurred during the preceding plan year until March 31 of the following plan year, to be reimbursed from your available General Purpose Medical Reimbursement Account amounts for the preceding plan year. In addition, you may elect prior to the beginning of a plan year to waive the carryover from the preceding plan year in accordance with procedures established by the Plan Administrator. A participant who waives the carryover may continue to submit claims for medical expenses incurred during the preceding plan year until March 31 of the following plan year, to be reimbursed from the participant's available Medical Reimbursement Account amounts.

If an expense is eligible for reimbursement under both the Limited (Vision/Dental) Medical Reimbursement Account and an HSA, you may choose to seek reimbursement from either the Limited (Vision/Dental) Medical Reimbursement Account or the HSA, but not both.

Dependent Care Expense Reimbursement

Reimbursement is available for expenses incurred for the care of a dependent under the age of 13, or a spouse or dependent who is physically or mentally unable to care for himself or herself, if such care enables you to be employed. Such expenses must not be reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your spouse's dependent care expense reimbursement plan). Reimbursement is not available for payments made to your spouse, your child if he or she is under the age of 19, or to any individual whom you can claim as a dependent on your tax return. If you use the Plan to pay for your dependent care expenses, you cannot use those same expenses for the tax credit on your federal income tax return. You may still be able to use a portion of the tax credit, but you will be limited.

Claims for reimbursement of dependent care expenses must be substantiated in the same manner as for medical care claims, as described above.

B. Are My Benefits Taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not subject to federal income tax under present law. Most states exclude benefits from state income tax. Not all states, however, exclude benefits from taxation. Neither the Employer nor the Plan Administrator can guarantee the tax treatment of any given participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser. It is your responsibility to determine whether any payment under the Plan is excludable from gross income for federal, state, and local income tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. Neither the Employer nor the Plan Administrator is liable for any taxes or penalties

you owe with respect to such amounts. If there are any taxes or penalties payable by the Employer on your behalf, such taxes or penalties shall be payable by you to the Employer to the extent such taxes would have been originally payable by you had the Plan not been in existence.

For information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA, see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

C. What Happens If My Employment Terminates During The Year?

If your employment with the Employer is terminated during the plan year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan. Your medical, dental, and/or vision coverage will terminate as of the date(s) specified in the applicable plans or insurance policies. Please refer to the sections and appendix regarding COBRA for information on your right to continued group health coverage after termination of your employment.

If you have ceased to be eligible as a participant, you will have until March 31 following the end of the plan year in which you cease to be eligible as a participant to submit claims for reimbursement for medical expenses incurred prior to the date on which you ceased to be eligible.

If you have ceased to be eligible as a participant, you will have until March 31 following the end of the plan year in which you cease to be eligible as a participant to submit a claim for reimbursement for dependent care expenses incurred prior to the date you ceased to be eligible.

For information about obtaining distributions from your HSA at any time, including after termination of employment, contact the trustee/custodian of your HSA.

For purposes of pre-taxing COBRA coverage for medical, dental, and/or vision insurance and Medical Expense Reimbursement account benefits, certain Employees may be able to continue eligibility in the Plan for certain periods. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." COBRA coverage under the Medical Expense Reimbursement account, including when it may become available to you and your family and what you need to do to protect the right to receive it, is described later in this SPD. Please refer to the summary plan descriptions for the medical, dental, and vision plans for information about COBRA continuation coverage under those plans.

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"). More information about coverage under USERRA is available from the Plan Administrator

CHANGING BENEFIT ELECTIONS

A. May I Change My Election During The Plan Year?

Except for elections to contribute to an HSA, the benefit elections that you make on your election form generally cannot be changed during the plan year to which they apply. (See the Article entitled "General Information About Our Plan" for the definition of "plan year.") There are, however, important exceptions to this general rule. We refer to these exceptions as Qualified Changes. If you experience a Qualified Change during the plan year, you may revoke your previous benefit elections and make new benefit elections that are consistent with your Qualified Change.

If you experience one of the events listed in this section and want to change your benefit elections, you must inform the Plan Administrator of your new election within 30 days of the event (or 31 days if authorized by the underlying benefit program). If you do not make a new election during the 30-day period, you will lose your right to change your benefit elections based on that event.

The Qualified Changes include the following:

1. Your legal marital status changes through marriage, divorce, legal separation, or marriage annulment;

2. The number of dependents you have for federal income tax purposes changes due to the birth of a child, adoption of a child, or placement of a child for adoption by you;

3. Your spouse or one of your dependents dies;

4. You, your spouse, or any other dependent begins or ends employment;

5. You, your spouse, or a dependent experiences a reduction or increase in hours of employment (including a switch between part-time and full-time, a strike or lockout, or the beginning or end of an unpaid leave of absence), or a change in employment status, which affects the ability of that person to participate in an employer-sponsored plan;

6. Your dependent begins to meet, or ceases meeting, the eligibility requirements for a dependent, because of age, student status, or a similar circumstance;

7. You, your spouse, or a dependent has a change in residence;

8. Only in regard to dependent care assistance: adoption proceedings commence or terminate for one of your dependents.

If you experience any of the events listed above, then you will be permitted to add or drop coverages, and make new benefit elections, which are consistent with that gain or loss. However, in order to make new benefit election in your accident coverage or health coverage, the event listed

above must also be one which has affected your, your spouse's, or your dependent's eligibility for coverage.

The following paragraphs describe more Qualified Changes.

If you, your spouse, or your dependent becomes eligible for COBRA continuation coverage under a plan sponsored by the Employer, you may elect to increase your premium payment election under this Plan in order to pay for the continuation coverage.

If you, your spouse, or your dependent becomes covered by a group health plan sponsored by the Employer as a special enrollee under Internal Revenue Code § 9801(f), then you may elect to increase your premium payment election under this Plan in order to pay for the new coverage. (See the next question for more information about Special Enrollment Rights.)

If an order, judgment, or decree resulting from a divorce, legal separation, annulment, or change in legal custody is issued requiring coverage for your child under a group health plan sponsored by the Employer, or requiring that your spouse, former spouse, or other individual provide coverage for the child, then you or the Plan may change your coverage accordingly and may change your benefit elections to reflect any change in the premium for such plan.

If you, your spouse, or one of your covered dependents becomes enrolled for health benefit coverage under Medicare or Medicaid, or loses such coverage, then you may reduce or add coverage for that person under a group health plan sponsored by the Employer, and you may change your benefit elections to reflect any change in the premium.

If you are absent from work for a leave covered by the FMLA, you may drop coverage under the Furman University Medical Plan (Plus Plan, Basic Plan, and HDHP H.S.A. Plan) or the Furman University Dental Plan during your leave and may change your elections to reflect the change in premium. You may also drop your participation in the medical expense reimbursement portion of this Plan. You may reinstate all of these when you return from leave. **Please note:** If you terminate your medical expense reimbursement contributions while you are on FMLA leave, you are not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If you choose to reinstate your medical expense reimbursement contributions upon return from FMLA leave, you will be able to be reimbursed for expenses incurred after reinstatement, but still will not be reimbursed for claims incurred during the period when coverage was terminated.

If you have elected to make premium payments for a group health plan through this Plan, and if the cost of those premiums changes during the plan year, your premium election will be adjusted automatically. However, if there is a significant change in the cost of your coverage, you will be permitted to change to another option under that plan which has a lower cost, change to a different option under that plan with similar coverage, or (if no similar coverage is available) drop coverage under that plan, and you will be permitted to make corresponding changes to your benefit elections.

If your dependent care provider imposes a cost change, you may change your election regarding dependent care assistance, but only if the provider is not your relative.

If the Plan adds a new benefit package option or coverage option, you may elect the newly added option prospectively. Likewise, if an existing benefit or coverage option is eliminated during a coverage period, you will be permitted to choose another option prospectively, and you will be permitted to make corresponding changes to your benefit elections.

You may make a benefit election change that is on account of and corresponds to a change made under any plan in which your spouse, former spouse or dependent participates, if the coverage period under that plan is different than the coverage period under this Plan.

If you, your spouse, or your dependent loses coverage under any group health coverage sponsored by a governmental or education institution (including a state children's health program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan), then you will be permitted to add coverage prospectively for that person under a group health plan sponsored by the Employer, and you will be permitted to make corresponding changes to your benefit elections.

If you are a member of the "highly-paid" group of employees (as defined by the Internal Revenue Code), the Plan Administrator may modify your elections downward during the plan year as necessary to prevent the Plan from becoming discriminatory within the meaning of federal tax law.

B. What Are Special Enrollment Rights?

If you, your spouse, or your dependent does not enroll in the Plan when first eligible, you may have a right to a "special enrollment" during the plan year. The special enrollment rights are as follows:

For Individuals Losing Other Coverage

You have special enrollment rights if all of the following conditions are met:

1. You were covered under a group health plan (including COBRA coverage), or had other health insurance, at the time you declined coverage under this Plan.

2. You lost your former coverage because:

    a. Your former coverage was COBRA coverage, and the entire COBRA coverage period was exhausted; or

    b. Your former coverage was not COBRA coverage, and you stopped being eligible for the coverage (this includes loss of eligibility due to separation, divorce, or termination of employment); or

    c. Your former coverage was not COBRA coverage, and your employer stopped contributing to the coverage.

Note: If you lost your former coverage because you decided to drop the coverage or you stopped paying for the coverage, you do not have special enrollment rights.

You must request special enrollment in this Plan not later than 30 days after the date on which you lost your former coverage.

If you meet the necessary conditions, coverage under this Plan will begin no sooner than the first day of the payroll period coinciding with or next following the date on which the Plan receives a new enrollment form.

For Individuals Acquiring a Spouse or a Dependent

If you get married, have a child, adopt a child, or have a child placed for adoption with you, you may make the following special enrollments:

1. If you are already a participant, you may enroll your spouse and/or your newly acquired dependent(s).

2. If you are eligible to participate but are not already enrolled, you may enroll yourself, together with your spouse, your newly acquired dependent(s), or both. You may not enroll your spouse or your dependent without enrolling yourself.

In the case of the birth or adoption of a child, other dependents may also be enrolled if they are otherwise eligible for coverage.

You must request special enrollment in this Plan no later than 30 days after the date of the marriage, birth, adoption, or placement for adoption.

In the case of marriage, coverage under this Plan will begin no sooner than the first day of the payroll period coinciding with or next following the date on which the Plan receives a new enrollment form.

In the case of birth, adoption, or placement for adoption, coverage under this Plan will begin no later than the date of the birth, adoption, or placement for adoption.

C. May I Make New Elections In Future Plan Years?

Yes, you may. For each new plan year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming plan year. Except as explained below under "Do Any Of My Elections Continue From Year To Year?," if you do not enroll during open enrollment, we will assume you do not want to continue your participation in the Plan. New elections must be made during the open enrollment period prior to the beginning of each plan year.

D. Do Any Of My Elections Continue From Year to Year? What If I Do Not Want My Elections To Continue For The Upcoming Plan Year?

Yes, your elections for medical, dental, and/or vision insurance continue from year to year unless you make an election change. For medical, dental, and/or vision insurance, your failure to complete a new enrollment form, or salary reduction agreement or make an election for the upcoming plan year will be deemed as your consent to continue your current elections for medical, dental, and/or vision insurance for the upcoming plan year (unless you experience an event that allows you to change your elections mid-year). During the open enrollment process, the Employer will provide you the salary reduction amounts for each type of insurance and each level of coverage (e.g., employee, employee + child(ren), employee + spouse, or employee + family). You may obtain a description of your existing coverage by contacting the Plan Administrator or by accessing the benefits section of your MyFurman account.

As described above under "May I Make New Elections In Future Plan Years?," you have the right to decline medical, dental, and/or vision insurance coverage (and not have salary reductions or coverage) or change your coverage options and elections for the upcoming plan year. To decline coverage, you must submit to the Plan Administrator a new election form and salary reduction agreement that indicates your new elections. You must submit the election for and salary reduction agreement to the Plan Administrator by the end of the open enrollment period (the specific date will be communicated to you by the Plan Administrator).

E. When May I Change The Amount I Elect To Contribute To An HSA?

An election to make a contribution to an HSA may be increased, decreased, or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed.

OPERATION

A. How Does This Plan Operate?

Before the start of each plan year, you will be able to elect to have some of your upcoming pay redirected to the Plan. These amounts will be recorded in special recordkeeping accounts called "benefit accounts." For each benefit you elect, a benefit account is used to keep track of your contributions, benefit reimbursements/payments, and forfeitures. The benefit accounts allow you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally would pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction for that expense on your tax return.

B. How Long Will The Plan Remain In Effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify, amend, revoke, or terminate the Plan as it sees fit at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended.

C. What Happens If My Employment Terminates?

If your employment terminates for any reason, your participation in the Plan will also terminate. You may, however, be permitted to make contributions to the Medical Expense Reimbursement portion of the Plan under the continuation coverage provisions that apply to medical benefits elected under the Plan, but this continuation coverage will last only through the end of the calendar year in which you terminate employment.

If you do not elect continuation coverage, reimbursement for expenses incurred prior to your termination of employment will be limited to the balance of the annual benefit you elected, reduced by any reimbursements you have already received during the plan year. You will have no right to any portion of the annual benefit you elected that is left over as of the end of the plan year, regardless of how much you contributed to the Plan.

You must submit any claims for reimbursement of expenses incurred prior to your termination of employment by March 31 following the end of the plan year during which your employment terminated. No cash refunds are available for unused amounts at the time of termination. Any expenses that are incurred after you terminate employment cannot be reimbursed.

D. What Is "Continuation Coverage" And How Does It Work?

"Continuation coverage" (also known as "COBRA Coverage") means your right, or your spouse's or dependent's right, to continue receiving reimbursement for certain medical expenses under this Plan, if participation by you or your spouse or dependents would otherwise end due to the occurrence of a "qualifying event." A qualifying event is:

1. termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below that required for eligibility under the Plan;

2. your death;

3. divorce or legal separation from your spouse;

4. your becoming entitled to receive Medicare benefits; and

5. your dependent ceasing to qualify as a dependent.

It is your obligation to inform the Plan Administrator of the occurrence of the following qualifying events within 60 days of the occurrence: (i) your divorce or legal separation from your spouse, and (ii) your dependent ceasing to qualify as a dependent. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with written notice of the options to continue the coverages provided through this Plan at stated premium costs with respect to each health plan in which you are a participant. The notification you receive will explain the terms and conditions of the continuation coverage.

For complete details on Continuation Coverage, please see the Continuation Coverage Notice which is attached to this Summary Plan Description as **Exhibit A**.

E. Will My Social Security Benefits Be Affected By My Participation In The Plan?

Your Social Security benefits may be affected, although we are unable to make a computation to determine the exact dollar amount in each person's particular circumstance. In most cases, though, any effect will be minimal compared to the amount of federal income tax savings that may be realized from participating in the Plan.

F. Does The Plan Modify My Employment?

No. The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

CONTRIBUTIONS

A. How Much Of My Pay May I Contribute To The Plan?

When you enroll in the Plan, you must elect the benefits you wish to pay for through salary redirection. You must also state the amount to be taken out of each paycheck during the plan year for contribution to the Plan. Your contributions are accounted for in one or more benefit accounts for the payment of benefits and permitted administrative expenses. The maximum amount (and minimum amount, where applicable) of contributions for a plan year is limited as follows:

- For Employer-sponsored medical, dental, or vision: your share of the premium.
- For HSA contributions: the statutory annual maximum amount for HSA contributions applicable to the participant's HDHP coverage option (i.e., single or family) for the calendar year in which the contribution is made. For 2017, the maximum HSA contributions are $3,400 (self-only coverage) and $6,750 (family coverage). An additional catch-up contribution may be made for participants who are age 55 or older. For 2017, the catch-up contribution amount is $1,000.
- For out-of-pocket medical expense reimbursements: the statutory annual maximum amount ($2,600 for 2017). The minimum annual required contribution is $100.
- For out-of-pocket dependent care expenses: the statutory annual maximum amount (discussed below). The minimum annual required contribution is $100.

Dependent care expenses are further limited to the lesser of $5,000 ($2,500 if you are married and file a separate tax return), your annual salary, or your spouse's annual salary. If your spouse is a student or incapable of caring for himself or herself, he or she is deemed to have a salary of $250 per month if you have one dependent, or $500 per month if you have two or more dependents.

B. How Is My Compensation Measured Under Our Plan?

Compensation means the total cash remuneration you receive from the Employer during a plan year prior to any reductions pursuant to an enrollment form and prior to any salary reduction pursuant to any of the following: (a) another cafeteria plan; (b) a Code Section 132(f)(4) plan; or (c) any retirement plan contribution.

C. What Happens To Contributions Made To The Plan?

Before each plan year begins, you will elect the benefits you would like to receive under the Plan. You will also elect the amount you will contribute to each elected benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the plan year. After each pay period, the contributions that were withheld from your paycheck will be accounted for using the benefit accounts. Later, your contributions will be used to pay for the expenses as they arise during the plan year.

D. Will My Benefit Accounts Earn Any Interest?

No interest or other earnings will be credited to your benefit accounts at any time. The benefit accounts are merely recordkeeping accounts with the purpose of keeping track of contributions, and reimbursements and determining forfeitures; the Employer does not create a separate fund or otherwise segregate assets for this purpose.

E. When Must I Decide Which Benefits I Want To Elect?

You are required by federal law to decide before the plan year begins, during the enrollment period. You must decide: (1) the benefits in which you want to participate; and (2) with respect to the HSA, Medical Expense Reimbursement, and Dependent Care Expense Reimbursement benefits, the amount you want to contribute to each benefit. If you elect to participate in the medical, dental, and/or vision insurance benefits, you will elect to pay the full amount of the required employee contribution through the Plan.

BENEFIT PAYMENTS

A. When Will I Receive Payments From The Medical Expense Reimbursement Or Dependent Care Expense Reimbursement Benefits?

During the course of the plan year, and until March 31 following the end of the plan year, you may submit requests for reimbursement of medical expenses or dependent care expenses you incurred during the plan year. These requests are called "claims." Medical expense and dependent care expense claims should be submitted to:

Flores & Associates, LLC
P.O. Box 31397
Charlotte, NC 28231-1397
http://www.flores247.com
1-800-532-3327

Expenses are considered "incurred" when the service is performed, not necessarily when you are formally billed or when charges for that service are paid. The Plan Administrator will provide you with appropriate forms for submitting your claim. If the claim qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements are generally not subject to income tax or withholding, nor are they subject to Social Security taxes.

B. What Amounts Are Available At A Particular Time For Reimbursement Under The Medical Expense Reimbursement And The Dependent Care Expense Reimbursement Benefits?

Under the Medical Expense Reimbursement benefit, reimbursement of eligible medical expenses, up to the total amount you have elected for the plan year, is available at any time during that year (less prior reimbursements). For example, if you elect to have $50 deducted per month for reimbursement of medical expenses, and you incur $300 worth of medical expenses in the second month of the plan year, you may request reimbursement for the entire $300, even though you have contributed only $100 to the Plan.

The amount of coverage that is available for reimbursement of qualifying dependent care expenses at any particular time during the plan year will be equal to the amount credited to your Dependent Care Expense Reimbursement account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the plan year.

C. How Are Insurance Premiums Paid?

Payment of medical, dental, and/or vision insurance premiums will be made directly to the insurer. The provisions of the insurance policies, or of the group health plan, will control what benefits will be paid and when.

D. How Are Medical Expenses Reimbursed From My HSA?

The Employer will forward contributions that you make via pre-tax salary reduction contributions to the HSA trustee/custodian. The Plan Administrator will maintain records to keep track of HSA contributions a participant makes via Salary Reduction contributions, but it will not create a separate fund or otherwise segregate assets for this purpose. The procedure for filing HSA claims and receiving reimbursements is determined by the HSA trustee/custodian, not by this Plan. Contact information for the HSA trustee/custodian is as follows:

Cigna
http://www.cigna.com
1-800-997-1654

E. What Happens If My Claim For Benefits Is Denied?

If your claim for reimbursement of a qualified medical expense is denied, or your claim for a premium payment is denied, you will have the rights specified in the "Medical Claim Procedures" which are attached to this Summary Plan Description as **Exhibit B**.

If your claim for reimbursement of a dependent care expense is denied, you will have the rights specified in the "Dependent Claim Procedures," which are attached to this Summary Plan Description as **Exhibit C**.

If your claim for reimbursement from your HSA is denied, the procedures established by the HSA trustee/custodian shall apply. Contact Cigna or the Plan Administrator for additional information.

F. What Happens If I Don't Spend All Of My Plan Dependent Care Expense Reimbursement Contributions?

Remember, you spend your Plan contributions by requesting reimbursement for a qualified dependent care expense. You must make your request for reimbursement no later than March 31 following the end of the plan year. After all such requests have been finally decided, any addition money left in your Dependent Care Expense Reimbursement account will be forfeited. Unused year-end account balances will not be carried over to the next plan year. Because it is possible that you might forfeit amounts in your Dependent Care Expense Reimbursement account if you do not fully use the contributions that have been made, it is important that you decide how much to contribute to that account carefully.

G. What Happens If I Don't Spend All Of My Plan Medical Expense Reimbursement Contributions? Does The Plan Permit Carryovers?

You may carry over to the subsequent plan year an amount, up to $500, in your Medical Expense Reimbursement Account remaining unreimbursed as of the end of the period for submitting eligible expenses (March 31 following the end of the plan year). The amount carried over may be used only to pay or reimburse medical expenses incurred during the entire plan year to which the amount is carried over. The amount remaining unused shall be calculated after all medical expenses have been reimbursed as soon as administratively feasible after the end of the period for submitting eligible expenses.

With respect to the carryover allowance described above, the amount that may be carried over to the following plan year is equal to the lesser of (1) any unused amounts from the immediately preceding plan year that is not submitted by March 31 following the end of the plan year, or (2) $500. Any unused amount in excess of $500 that remains unused as of the end of period for submitting eligible expenses is forfeited. For ease of administration, reimbursements of all claims for expenses that are incurred in the current plan year shall be treated as reimbursed first from unused amounts credited for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused amounts carried over from the preceding plan year. Any unused amounts from the prior plan year that are used to reimburse a current plan year expense (a) reduce the amounts available to pay prior plan year expenses during the period for submitting eligible expenses, (b) must be counted against the permitted carryover of up to $500, and (c) cannot exceed the permitted carryover.

H. How Are Forfeitures Used?

Forfeitures from the Medical Expense Reimbursement accounts will be used by the Employer to offset any losses of the Employer under the Medical Expense Reimbursement benefit,

or to reduce costs of administration, and then in any manner authorized by applicable law. Forfeitures from the Dependent Care Expense Reimbursement accounts will be used by the Employer to reduce costs of administration, and then in any manner authorized by applicable law.

I. May I Withdraw Cash From Any Of My Benefit Accounts?

No. Your benefit account balances may be used only to provide premium payments or expense reimbursement benefits, as the case may be. Of course, you may make withdrawals or receive reimbursements from your HSA.

J. May I Shift Amounts From One Benefit Account To Another?

No. You may not transfer credits or amounts from one benefit account to another. Thus, for example, credits to your Medical Expense Reimbursement account may be used only for that type of expense; no amount in that account will be available for any other purpose.

K. Do I Pay Any Administrative Costs Under The Plan?

No. The cost is paid in part by the use of forfeitures, if any. The rest of the cost of administering the Plan is paid entirely by the Employer. A separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian for your HSA established and maintained by you outside of the Plan. Such fees are paid by the Employer.

L. What Are Qualified Reservist Distributions?

Effective June 17, 2008, you may request a Qualified Reservist Distribution of any unused balance in your Medical Expense Reimbursement account.

A Qualified Reservist Distribution is a distribution of all or a portion of your Medical Expense Reimbursement account if:

- You were ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and

- The distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year you receive your order or call.

M. What Is The Newborns' And Mothers' Health Protection Act Of 1996?

Under ERISA, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PLAN ACCOUNTING

The Plan Administrator will provide you with a statement of your account during the plan year that shows your account balance. It is important to read these statements carefully so you understand the amounts remaining in each reimbursement account. Remember, you want to spend all the money in each reimbursement account by the end of the plan year.

GENERAL INFORMATION ABOUT YOUR PLAN

Plan Name. The name of the Plan is the Furman University Section 125 Cafeteria Plan and Furman University Flexible Spending Account Plan. This Plan is a component of the Furman University Health Wrap Plan.

Plan Number. The Furman University Health Wrap Plan is plan number 507.

Employer Information.

Furman University
3300 Poinsett Highway
Greenville, South Carolina, 29613
864-294-2217 (Phone)
864-294-3678 (Fax)
HumanResources@Furman.edu (email)

EIN: 57-0314395

Type of Plan. The Furman University Section 125 Cafeteria Plan and Furman University Flexible Spending Account Plan is an employee welfare benefit plan providing medical, dental, and vision benefits, health flexible spending arrangement benefits, dependent care expense reimbursement benefits, and pre-tax contributions to health savings accounts. The Plan is a "cafeteria plan" under § 125 of the Internal Revenue Code.

Type of Administration. The Plan is administered by the Employer, which has contracted with Flores to provide administrative services for the health flexible spending arrangement benefits and dependent care expense reimbursement benefits.

Plan Administrator Information.

Furman University
3300 Poinsett Highway
Greenville, South Carolina, 29613
864-294-2217 (Phone)
864-294-3678 (Fax)
HumanResources@Furman.edu (email)

Agent for Service of Legal Process.

Furman University
3300 Poinsett Highway
Greenville, South Carolina, 29613
864-294-2217 (Phone)
864-294-3678 (Fax)
HumanResources@Furman.edu (email)

Service of legal process may also be made upon the Plan Administrator.

Collective Bargaining Agreement ("CBA"). The Plan is not maintained pursuant to a CBA.

Eligibility for Participation and Benefits. The Plan's requirements for participation and benefits are set forth earlier in this SPD.

Summary of Benefits. The benefits provided under this Plan are summarized earlier in this SPD.

Qualified Medical Child Support Orders ("QMCSOs"). To the extent required by law, if an Employee's Dependent is an "alternate recipient" described in a medical child support order, and if the Plan Administrator determines the order to be a QMCSO under ERISA Section 609, the benefit to which the QMCSO relates will be available to the Dependent. QMCSO procedures are available from the Plan Administrator upon request.

Loss of Eligibility and Benefits. The circumstances which could result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits are summarized earlier in this SPD.

COBRA. Some of the benefits offered by the Plan are subject to the laws concerning continuation coverage. A notice explaining your continuation coverage rights is set forth as an exhibit to this SPD.

Plan Funding. Contributions to the Plan are made by the Employer and the Employees through salary-reduction arrangements. The amount of the employee contributions are determined by the employees at the time of enrollment, subject to certain limits as required by law or as set forth in the Plan document.

Funding Medium. The Furman University Medical Plan is self-funded. The Furman University Dental Plan is an insured plan. The Furman University Vision Plan is an insured Plan. The Medical Expense Reimbursement and Dependent Care Expense Reimbursement benefits are self-funded. The cost of each benefit is paid through Employee salary deferrals and/or Employer contributions from the Employer's general assets. The assets of the Plan are not held in a trust, and Plan Benefits are not funded by a trust.

Plan Year. The plan year is the 12-month period ending on December 31.

Further Information. An Employee may obtain further information about the Plan by contacting the Plan Administrator.

Inspection of Plan. The Employer will make the Plan and all related documents incorporated herein by reference available for inspection at its offices at no cost upon reasonable notice.

Copy of Plan. Upon reasonable notice and written request a copy of this Plan may be obtained from the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

HIPAA Notice of Privacy Practices. You have been furnished a Notice of Privacy Practices describing the practices the Plan will follow with regard to your "protected health information" relating to your medical reimbursement account. If you would like to receive another copy, please contact the Plan Administrator.

ERISA RIGHTS

The Plan and the HSA and Dependent Care Expense Reimbursement components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"). However, the Medical Expense Reimbursement and the medical, dental, and vision plans are governed by ERISA. Note: This SPD does not describe the medical, dental, and vision plans. Consult the medical, dental, and vision plan documents and the separate summary plan descriptions for the medical, dental, and vision plans. This SPD also does not describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified work locations, all documents governing the Plan, including copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

Obtain, upon written request to the Plan Administrator copies of all Plan documents and other Plan information. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to

pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP")

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from its Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your state for more information on eligibility.

ALABAMA – Medicaid	**INDIANA** – Medicaid
Website: http://www.myalhipp.com/ Phone: 1-855-692-5447	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid: Website: http://www.indianamedicaid.com Phone: 1-800-403-0864
ALASKA – Medicaid	**IOWA** – Medicaid
Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: www.dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
ARKANSAS – Medicaid	**KANSAS** – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-692-7447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

COLORADO – Medicaid & CHIP	**KENTUCKY** – Medicaid
Medicaid website: https://www.healthfirstcolorado.com/ Medicaid phone: 1-800-221-3943 CHIP website: Colorado.gov/HCPF/Child-Health-Plan-Plus CHIP phone: 1-800-359-1991	Website: http://chfs.ky.gov Phone: 1-800-635-2570
FLORIDA – Medicaid	**LOUISIANA** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
GEORGIA – Medicaid	**MAINE** – Medicaid
Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid & CHIP	**OKLAHOMA** – Medicaid & CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MINNESOTA – Medicaid	**OREGON** – Medicaid
Website: http://www.mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Websites: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MISSOURI – Medicaid	**PENNSYLVANIA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
MONTANA – Medicaid	**RHODE ISLAND** – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ohhs.ri.gov/ Phone: 855-697-4347
NEBRASKA – Medicaid	**SOUTH CAROLINA** – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA** – Medicaid
Website: http://dhcfp.nv.gov/ Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS** – Medicaid
Website: http://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid & CHIP	**UTAH** – Medicaid & CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid website: https://medicaid.utah.gov/ CHIP website: http://health.utah.gov/chip Phone: 1-877-543-7669

NEW YORK – Medicaid	**VERMONT** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA** – Medicaid & CHIP
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid phone: 1-800-432-5924 CHIP phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	**WYOMING** – Medicaid
Website: http://mywvhipp.com Phone: 1-855-699-8447	Website: http://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
WISCONSIN – Medicaid & CHIP	
Website: http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	

To see if any more states have added a premium assistance program since July 31, 2018 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

SUMMARY

Since this document is a summary, it cannot contain all of the details of the cafeteria plan, which is a technical legal document. Accordingly, if there are any conflicts or inconsistencies between this SPD and the Plan, the provisions of the Plan will govern. When making any decision affecting your rights under the Plan you should rely on the provisions of the Plan rather than on this summary. Any participant or beneficiary may arrange to see a copy of the Plan document during regular business hours by contacting the Plan Administrator.

As always, please check with your personal financial, tax, and legal advisors in regard to any issues related to your participation in the cafeteria plan.

EXHIBIT A
CONTINUATION COVERAGE NOTICE

Introduction

This Exhibit has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under certain group health plans. This Article explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. It can also become available to other members of your family who are covered under certain group health plans when they would otherwise lose their group health coverage.

This Exhibit applies to the following benefits offered through the Plan:

- Medical plan
- Dental plan
- Vision plan
- The health flexible spending arrangement

This Exhibit generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (sometimes referred to as an Exchange). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 31-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this Exhibit. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

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

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

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Furman University, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

a. The end of employment or reduction of hours of employment;
b. death of the employee;
c. Commencement of a proceeding in bankruptcy with respect to the Employer; or
d. the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Oral notice, including notice by telephone, is not acceptable. You must provide this notice to:

Flores & Associates
P.O. Box 31397
Charlotte, NC 28231-1397

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the qualified beneficiary(ies)**, and
- the **qualifying event** and the **date** it happened.

If the qualifying event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under a group health plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time

before the sixtieth day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the group health plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Continuation Coverage and Health Flexible Spending Accounts

You can elect to continue your participation in the health flexible spending arrangement for the remainder of the plan year, subject to the following conditions. You may continue to participate in the health flexible spending arrangement only if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the health flexible spending arrangement. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to provide this benefit.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace (sometimes referred to as an Exchange), Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your Component Health Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more

information about the Marketplace (sometimes referred to as the Exchange), visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have COBRA questions, please contact:

Flores & Associates
P.O. Box 31397
Charlotte, NC 28231-1397
(800) 532-3327 (Phone)
(800) 726-9982 (Fax)

EXHIBIT B
MEDICAL EXPENSE CLAIM PROCEDURES

Claims for Medical, Dental, and Vision Benefits

You are not required or permitted to file claims for the payment of medical, dental, and vision benefits paid on a pre-tax basis. If, however, the Employer fails to pay medical, dental, or vision premiums due using amounts withheld pursuant to a valid Salary Reduction Agreement, the claim procedures set forth in the Furman University Health Wrap Plan (of which this Plan is a component) shall control.

Claims for HSA Benefits

The procedure for filing HSA claims is determined by the HSA trustee/custodian, not by this Plan. Please contact the HSA trustee/custodian for information regarding submitting claims for reimbursement.

Claims for Health Flexible Spending Arrangement Benefits

Any claim for benefits under this Plan is to be submitted to the entity that has been retained to provide claims administration, hereafter the Claims Administrator. Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc. was relied on and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process

In the event a claim for benefits is denied, the claimant, or his or her duly authorized representative, may appeal the denial to the Committee within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or the participant will lose the right to appeal the denial and the right to file a civil action in court as provided by ERISA. In pursuing an appeal, the claimant or the duly authorized representative:

1. must request in writing that the Committee review the denial;

2. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

3. may submit written issues and comments, documents, records, and other information regarding the claim.

The appeal will be reviewed by the Committee, and written comments, documents, records, and other information submitted by the participant will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of the appeal. If the decision on review is adverse to the claimant, the written decision will be written in a manner calculated to be understood by the claimant and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, the claimant will be provided either the specific rule, guideline, protocol, or other similar criterion, or will be given a statement that such rule, guideline, etc. was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, the claimant will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and the participant will have the right to pursue his or her claim under ERISA, including the right to file a lawsuit.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

Notwithstanding the foregoing, any claim which arises under any insurance contract(s) or Health Care Plan or other employee benefit plan that is not a Flexible Spending Account covered by this Plan shall not be subject to review under this Plan.

A claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a claim.

EXHIBIT C
DEPENDENT CARE EXPENSE CLAIM PROCEDURES

I. Initial Claim

A. Submitting the Claim. Upon request, the Plan Administrator shall provide any participant or beneficiary ("Claimant") with a claim form which the Claimant can use to request benefits. In addition, the Plan Administrator will consider any written request for benefits under the Plan to be a claim.

B. Approval of Initial Claim. If a claim for benefits is approved, the Plan Administrator shall provide the Claimant with written or electronic notice of such approval. The notice shall include:

1. The amount of benefits to which the Claimant is entitled.

2. The duration of such benefit.

3. The time the benefit is to commence.

4. Other pertinent information concerning the benefit.

C. Denial of Initial Claim. If a claim for benefits is denied (in whole or in part) by the Plan Administrator, the Plan Administrator shall provide the Claimant with written or electronic notification of such denial within 90 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. The notice of denial of the claim shall include:

1. The specific reason that the claim was denied.

2. A reference to the specific Plan provisions on which the denial was based.

3. A description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary.

4. A description of the Plan's appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on appeal.

The Claimant (or his or her duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Plan Administrator. The Claimant may appeal the denial as set forth in the next section of this procedure. **If the Claimant fails to appeal such action to the Plan Administrator in writing within the prescribed period of time described in the next section, the Plan Administrator's denial of a claim shall be final, binding, and conclusive.**

II. Appeal Procedures

A. Filing the Appeal. In the event that a claim is denied (in whole or in part), the Claimant may appeal the denial by giving written notice of the appeal to the Plan Administrator within 60 days after the Claimant receives the notice of denial of the claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the claim. The Plan Administrator shall review and consider this information without regard to whether the information was submitted or considered in conjunction with the initial claim.

B. General Appeal Procedure. The Plan Administrator (or its designee) may hold a hearing or otherwise ascertain such facts as it deems necessary and shall render a decision which shall be binding upon both parties. The Plan Administrator shall render a decision on appeal within 60 days after the receipt by the Plan Administrator of the notice of appeal, unless special circumstances require an extension of time. (See Section III for the procedures concerning extensions of time.) In deciding the appeal:

1. No deference shall be given to the decision denying the initial claim.

2. The appeal shall be decided by an individual who did not decide the initial claim and who is not a subordinate of anyone who decided the initial claim.

C. Notice of Decision on Appeal. The appeal decision of the Plan Administrator shall be provided in written or electronic form to the Claimant. If the appeal decision is adverse to the Claimant, then the written decision shall include the following:

1. The specific reason or reasons for the appeal decision.

2. Reference to the specific Plan provisions on which the appeal decision is based.

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. (Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to 29 C.F.R. § 2560.503-1(m)(8).)

4. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

5. A statement of the Claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act.

6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find

out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

III. Extensions of Time

A. Notice of Extension. If the Plan Administrator requires an extension of time, the Plan Administrator shall provide the Claimant with written or electronic notice of the extension before the first day of the extension. The notice of the extension shall include:

1. An explanation of the circumstances requiring the extension. These circumstances must be matters beyond the control of the Plan or the Plan Administrator.

2. The date by which the Plan Administrator expects to render a decision.

3. The standard on which the Claimant's entitlement to a benefit is based.

4. The unresolved issues, if any, that prevent a decision on the claim or on appeal, and the information needed to resolve those issues. In the event that such information is needed:

   a) The Claimant shall have at least 45 days in which to provide the specified information.

   b) The time for determining an initial claim shall be tolled from the date on which the notice of extension is sent to the Claimant, until the date on which the Claimant responds to the request for additional information.

B. Length of Extension

1. For purposes of an initial claim, no more than one extension of 90 days shall be allowed.

2. For purposes of an appeal, no more than one extension of 60 days shall be allowed.

A claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a claim.