RHODE ISLAND SCHOOL OF DESIGN
WRAP CAFETERIA PLAN

Rhode Island School of Design has adopted this Wrap Cafeteria Plan to provide participants with a way to purchase Qualified Benefits and, where permitted by law, to do so on a pre-tax basis. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent with Section 125 of the Code, and serve as the Plan document and summary plan description required under ERISA, to the extent ERISA applies.

SECTION 1. GENERAL INFORMATION.

Effective Date of Restatement	April 1, 2022
Plan Number	555
Plan Type	Wrap-style cafeteria plan, offering participants the ability to select from the following benefits: • Medical • Prescription Drug • Dental • Vision • Health Care Flexible Spending Account ("FSA") • Short-term disability • Long-term disability • Basic life insurance • Accidental death and dismemberment insurance • Employee Assistance Plan Each of these benefits are provided under separate insurance contracts underwritten by third-party insurers or under administrative service contracts listed on **Schedule A**.
Plan Sponsor	Rhode Island School of Design 2 College Street Providence, Rhode Island 02903 (401) 454-6100
Employer Identification Number	05-0258956
Plan Administrator	Plan Sponsor
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Source of Contributions	The medical, prescription drug, and FSA and short-term disability benefits are self-insured by the Plan Sponsor, and the other benefits are fully insured. The Plan Sponsor pays the full cost of some benefits, the Plan Sponsor and participants share in the cost of other benefits, and employees pay the full cost of other benefits that can be selected through the Plan. See **Schedule A** for details.
Taxability of Benefits	Benefits under this plan are intended to be offered on a pre-tax or after-tax basis, depending on the benefit, although there is no guarantee of any particular tax treatment. See **Schedule A** for information on whether a particular benefit is pre-tax or after-tax.

SECTION 2. DEFINITIONS.

Wherever used in this Plan, the singular includes the plural and the following capitalized terms have the following meanings, unless a different meaning is clearly required by the context:

2.1 "Administrator" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

2.2 "Benefit Document" means the benefit summary or plan document for each of the Qualified Benefits set forth in **Schedule A**.

2.3 "Child" or "Children" means a child of a participant, under the meaning set forth in the applicable Benefit Document; *provided, however*, that for Medical, Prescription Drug, Dental, Vision, and FSA coverage, the term "Child" includes children to age 26, regardless of status as a Dependent. Eligible Employees may be requested to provide satisfactory proof of status for any Child.

2.4 "Claims Administrator" means the entity or entities designated by the Company or the Administrator (or a delegate of either) from time to time to administer and process claims under any self-insured Qualified Benefit under the Plan.

2.5 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended from time to time, including regulations and guidance promulgated thereunder.

2.6 "Code" means the Internal Revenue Code of 1986, as amended from time to time, and the regulations and guidance promulgated thereunder.

2.7 "Company" means Rhode Island School of Design.

2.8 "Dependent" means an individual that is a dependent (as defined in Section 152 of the Code, without regard to Sections 152(b)(1), (b)(2), or (d)(1)(B)) with respect to a participant. Eligible Employees may be requested to provide satisfactory proof of status for any Dependent.

2.9 "Domestic Partner" means an individual that meets the requirements for coverage as a domestic partner under the applicable Qualified Benefit and is not a Spouse; provided, however, that contributions may be made to this Plan on behalf of a Domestic Partner only if the Domestic Partner is a Dependent.

2.10 "Eligible Employee" means an individual employed by the Company, other than those employed on a temporary or seasonal basis, providing services as an independent contractor, placed with the Company as a leased employee, or otherwise not reported on Company payroll records as an employee.

2.11 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time, including regulations and guidance promulgated thereunder.

2.12 "Key Employee" means any person defined in section 416(i)(1) of the Code, with respect to the Company.

2.13 "Plan" means the Rhode Island School of Design Wrap Cafeteria Plan as set forth herein, together with any and all Schedules, amendments, and supplements hereto.

2.14 "Plan Year" means January 1 through December 31 of each year.

2.15 "Qualified Benefits" means the benefits under the plans set forth in **Schedule A**, so long as such benefits are permitted as "qualified benefits" under Section 125 of the Code.

2.16 "Qualifying Event" has the meaning assigned by COBRA, and generally means for employees, a reduction in hours of employment (including failure to return to work after a leave taken under the Federal Family and Medical Leave Act) or termination of employment for reasons other than gross misconduct; for Spouses, in addition to the foregoing, death of the participant, divorce or legal separation from the participant, or the participant becoming entitled to (that is, covered by) Medicare and revoking coverage under the Plan; and for Children, in addition to the foregoing, ceasing to be eligible under the Plan.

2.17 "Spouse" means the legal spouse of an Eligible Employee, and a former spouse of an Eligible Employee if coverage of the former spouse is required by a divorce decree and/or applicable law.

SECTION 3. ELIGIBILITY AND PARTICIPATION.

3.1 Eligibility. All Eligible Employees are eligible to participate in this Plan. Eligibility to participate in any Qualified Benefit plan – such as the Medical, Prescription Drug, Dental, FSA, or Vision coverage – is determined under the provisions of the applicable Benefit Document. Without limiting the foregoing, in general, in most cases, employees of the Company that are scheduled to work fewer than 17.5 hours per week and 910 hours per year are not eligible for Qualified Benefits. See **Schedule A** for details on the eligibility requirements for each Qualified Benefit.

3.2 Commencement of Participation. An individual becomes a participant in this Plan on the first of the month coinciding with or following the date of hire, and elects to participate by filing a payroll deduction authorization pursuant to Section 5. Participation in any Qualified Benefit plan commences at the time and manner determined under the provisions of the applicable Benefit Document.

3.3 Termination of Participation. An individual will cease to be a participant in this Plan as of the earlier of (a) the date on which the Plan terminates or (b) the date on which the individual ceases to be an Eligible Employee, subject to Section 3.4 (COBRA rights). Participation in any Qualified Benefit plan ceases at the time and manner determined under the provisions of the applicable Benefit Document.

3.4 COBRA Continuation Coverage.

a) *Eligibility for COBRA Coverage*. Any participant, Spouse, or Child who is covered by the Plan on the day before a Qualifying Event, and any Child born to or adopted by/placed for adoption with the participant during the COBRA continuation coverage period, may elect to continue coverage under this Plan if s/he:

i. loses coverage under the Plan on account of a Qualifying Event;

ii. notifies the Plan Administrator of the Qualifying Event (in the case of (A) divorce or legal separation or (B) a Child ceasing to be eligible under the Plan) within 60 days of the Qualifying Event, in the method determined by the Administrator;

iii. elects COBRA continuation coverage within the later of 60 days after the date of the notice, or 60 days after the date the Qualified Beneficiary's coverage otherwise ends, in the method prescribed by the Administrator; and

iv. pays the COBRA premiums timely, meaning within 45 days after the day on which the Qualified Beneficiary elected COBRA continuation coverage (for the first month) and the first day each month thereafter, with a grace period of 30 days following the due date.

b) *Nature of COBRA Coverage*. Generally, COBRA continuation coverage is the same as provided under the Plan to similarly situated active participants and dependents. Qualifying Beneficiaries will continue to have open enrollment rights under the Plan for the duration of their COBRA continuation coverage.

c) *Duration and Termination of COBRA Coverage*. Qualifying Beneficiaries will be allowed to continue coverage under this Plan for the maximum COBRA continuation coverage period applicable. Generally, the maximum COBRA continuation coverage period is 18 months (for termination of employment/ reduction of hours) and 36 months (for other reasons). COBRA continuation coverage under the Plan will end on the first of: (i) the end of the maximum COBRA continuation coverage period; (ii) the end of the last month for which the Qualified Beneficiary has properly paid the required premium for COBRA continuation coverage; (iii) the date the Plan terminates; (iv) the first date, after a COBRA election, on which the Qualified Beneficiary becomes covered under another group health plan, entitled to Medicare, or determined by the Social Security Administration to be no longer disabled; or (v) the date the Qualified Beneficiary commits fraud or deception in the use of Plan services.

3.5 Reinstatement. A former participant in this Plan will become a participant on the date, if any, on which the former participant again becomes an Eligible Employee.

SECTION 4. QUALIFIED BENEFITS.

4.1 Qualified and Nonqualified Benefits. Only Qualified Benefits are provided under this Plan. Qualified Benefits are listed on **Schedule A**. No benefits determined to be "nonqualified" under Section 125 of the Code may be provided under this Plan, whether on a pre-tax or after-tax basis, including but not limited to long-term care insurance, long-term care services, group-term life insurance on the life of any individual other than an employee, health reimbursement arrangements, or elective deferrals to a section 403(b) plan.

4.2 Provided Outside of this Plan. Qualified Benefits are not provided not by this Plan but by the plans identified in **Schedule A**. The terms, conditions, and benefit descriptions in such plans, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3 Eligibility and Other Terms and Conditions. The types and amounts of benefits available, the requirements for eligibility and participation, and the other terms and conditions of coverage are as set forth from time to time in the plans identified in **Schedule A**, and in any Benefit Documents, and any group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference in) those plans; *provided, however*, that only Eligible Employees may elect benefits under the Qualified Benefit plans; and *provided, further*, that Eligible Employees who are full-time faculty members are not eligible for Vision benefits; and *provided, further*, that Eligible Employees who are part-time faculty members (a) are only eligible for Medical, Prescription Drug, and Dental benefits; (b) must agree to be paid over a twelve (12) month schedule from July through June, and to have their deductions spread over a twelve (12) month period; and (c) for those part-time faculty that are part of a bargaining unit, only if they are members of that bargaining unit.

SECTION 5. ELECTION PROCEDURES.

5.1 Choice of Cash or Qualified Benefits. Each participant may choose under this Plan to receive the participant's full compensation in cash or to have all or a portion of it applied toward the participant's share, if any, of the cost of the Qualified Benefits that are available to the participant. If a participant elects coverage for a Plan Year under a plan identified on **Schedule A**, and if the participant is required to pay a share of the cost of such coverage, such share shall be paid by means of a reduction in the participant's regular compensation for the Plan Year.

5.2 Election Procedures.

a) *In General*. Prior to the commencement of each Plan Year, the Administrator shall provide (or make available) a means of election for each participant and for each other individual who is expected to become a participant at the beginning of the applicable Plan Year. The Administrator may, in its discretion, use any telephonic, electronic, or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan. The election shall be effective as of the first day of the Plan Year; *provided, however*, that commencement of coverage under certain Qualified Benefits, such as life or LTD, may not coincide with the Plan Year because it may require underwriting approval. Each participant who desires to elect a Qualified Benefit available for the Plan Year shall so specify in his or her election. The participant shall agree to a reduction in his or her compensation equal to the cost of the Qualified Benefits elected by the participant. Each election must be completed and returned to the Administrator on or before such date as the Administrator shall specify.

b) *New Participants*. Before, or as soon as practicable after, an Eligible Employee becomes a participant, the Administrator shall provide the means of election to the Eligible Employee. If the Eligible Employee desires one or more Qualified Benefits for the balance of the Plan Year, the Eligible Employee shall so specify in his or her election. The Eligible Employee shall agree to a reduction in his or her compensation equal to the cost of the Qualified Benefits elected by the Eligible Employee. Each election must be

completed and returned to the Administrator on or before such date as the Administrator shall specify.

c) *Failure to Make Election*.

i. A new participant's failure to make an election on or before the due date specified by the Administrator for the Plan Year shall constitute an election by the participant: (A) if no Qualified Benefits were in place on the date on which he or she becomes a participant, an election to receive his or her full compensation in cash; or (B) if one or more Qualified Benefits were in place on the date on which he or she becomes a participant, an election to continue those same coverage or coverages (to the extent such coverage remains available as a Qualified Benefit and the participant remains eligible for such coverage), and an agreement to a reduction in the participant's compensation equal to the cost of such coverage or coverages.

ii. An existing participant's failure to make an election on or before the due date specified by the Administrator for any subsequent Plan Year shall constitute: (A) a re-election of the same coverage or coverages, if any, as were in effect just prior to the end of the preceding Plan Year (to the extent such coverage remains available as a Qualified Benefit and the participant remains eligible for such coverage), and (2) an agreement to a reduction in the participant's compensation for the subsequent Plan Year equal to the cost of such coverage or coverages.

d) *Maximum Elective Contributions*. The maximum amount of elective contributions under the Plan for any participant shall be the total cost to the participant for the Plan Year of the most expensive Qualified Benefits that any participant could elect.

5.3 Revocation or Change of Election by the Participant During the Plan Year. Any election made under the Plan (including an election made through inaction under Section 5.2(c)) shall be irrevocable by the participant during the Plan Year; *provided, however,* that a participant may revoke an election for the balance of the Plan Year and, if desired, file a new election if, under the facts and circumstances: (1) a change in status occurs, as described in Section 5.3(a); and (2) the requested revocation and new election are "consistent with" the change in status, as described in Section 5.3(b). Application for a revocation of an election and/or a new election must be in writing and made no later than thirty (30) days after the date of the actual event.

a) A "change in status" means:

i. *Change in Legal Marital Status*. An event that changes a participant's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

ii. *Change in Number of Covered Dependents*. An event that changes a participant's number of Dependents (including birth, death, adoption or placement for adoption) or an event that causes a dependent to satisfy or cease to satisfy the requirements for coverage (such as attainment of a certain age, change in student status, or any similar circumstance).

iii. *Change in Employment Status*. An event that changes the employment status of the participant or the participant's spouse or Dependent, including termination or commencement of employment, a strike or lockout, or a commencement or return from an unpaid leave of absence, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his or her employer.

iv. *National Medical Child Support Order*. The entry, modification, or revocation of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody determined by the Administrator to be a national medical child support order under § 401(f) of the Child Support Performance and Incentive Act of 1998 (a "NMCSO") that requires accident or health coverage for a participant's Child.

v. *Entitlement to Medicare or Medicaid.* In the event that the participant, his/her Spouse, and/or one or more of his/her Dependents becomes entitled to coverage under Part A or Part B of Medicare or under

Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act, or the participant, his/her Spouse, and/or one or more of his/her Dependents who has been entitled to Medicare or Medicaid loses eligibility for such coverage.

vi. *Change in Qualified Benefits*. If a new Qualified Benefit Coverage becomes available, or an existing Qualified Benefit Coverage is eliminated, during the Plan Year.

vii. *COBRA and Other Continuation Coverage*. If the participant, Spouse, or Dependent becomes eligible for continuation coverage under the group health plan of the employee's employer as provided in section 4980B or any similar state law, to increase payments in order to pay for the continuation coverage.

viii. *Significant Cost Changes.* If the cost charged to a participant for a Qualified Benefit significantly increases or significantly decreases during a period of coverage, whether resulting from an action taken by the Eligible Employee or from an action taken by the Company (such as increasing the employee contributions for a class of employees).

ix. *Other Changes*. Any other change authorized by the policies of the Company from time to time and permissible under Section 125 of the Code and the regulations and guidance issued thereunder.

b) A participant's requested revocation and new election will be "consistent" with a change in status if the election change is: (1) on account of such change in status and (2) corresponds with such change in status. Without limiting the generality of the foregoing:

i. A participant may change his or her election: (A) in order to provide coverage for the participant's Child under a health coverage identified on **Schedule A** if an NMCSO (as defined in Section 5.3(a)(iv) so requires; or (B) in order to cancel a health coverage identified on **Schedule A** for the participant's Child if a NMCSO requires the participant's spouse or former spouse or another individual to provide coverage for the Child.

ii. A participant may cancel or reduce such medical coverage for his/her Spouse of the participant to the extent that the Spouse becomes entitled to coverage under Part A or Part B of Medicare or under Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act, and may commence or increase a medical coverage identified on **Schedule A** if the Spouse who has been entitled to Medicare or Medicaid loses eligibility for such coverage.

iii. A participant who receives a Qualified Benefit, was not required to contribute toward a Qualified Benefit at the beginning of the Plan Year, and becomes required to so contribute during a Plan Year, may change his election to have part of his or her compensation applied toward the participant share of the cost of such Qualified Benefit.

c) Any revocation and new election under this Section 5.3 shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.

5.4 Adjustment of Compensation Reductions. If the cost of a Qualified Benefit (or of the participant's share of the cost of a Qualified Benefit) increases or decreases during a Plan Year, including any increase or decrease due to a change in the participant's salary, a corresponding change shall be made in the salary reductions of the participant in an amount reflecting such increase or decrease, as determined by the Administrator.

5.5 Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 5.2(c)) shall automatically terminate on the date on which the participant ceases to be a participant as described in Section 3.3, although coverage may continue under this Plan if and to the extent provided under Section 3.4 (relating to continuation coverage under COBRA) and under a plan identified on **Schedule A** if and to the extent provided under the applicable Benefit Document. In the event such a former participant again becomes a participant before the end of the same Plan Year, the employee will be required to make new elections in accordance with Section 5.2(a) or (b).

5.6 Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may permit

a participant to revoke (and subsequently reinstate) election of one or more Qualified Benefits under the Plan and adjust a participant's compensation reduction as a result to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1996 ("FMLA").

SECTION 6. HEALTH CARE FLEXIBLE SPENDING ACCOUNT.

6.1 In General. The Health Care Flexible Spending Account ("FSA") is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections and the applicable Treasury Regulations.

6.2 Coordination with Cafeteria Plan. Eligible Employees listed in **Schedule A** are eligible to participate in the FSA. Except as otherwise explicitly described in this Section, all provisions concerning contributions, elections, and the like shall be governed by Section 5 above.

6.3 Allocations. The FSA for each Eligible Employee will be credited with amounts withheld in accordance with his or her salary election under Section 5. The entire annual amount elected for the Plan Year, less any reimbursements already disbursed, shall be available to the Eligible Employee at any time during the Plan Year, without regard to the balance in the FSA; provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement. Notwithstanding any provision contained in this Plan to the contrary, Eligible Employees may allocate no more than $2,750 (as may be adjusted by the IRS from time-to-time) to the FSA in any Plan Year.

6.4 Distributions. Distributions shall be made from the FSA to pay for Eligible Expenses for the Participant, Spouse, and Dependents that are: (i) incurred in the Plan Year (or during the grace period, as and to the extent provided in Section 6.5), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

a) For purposes of the FSA, "Eligible Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used as a deduction in determining your tax liability under the Code; provided, however, that Eligible Expenses do not include the cost of over-the-counter drugs or medications, other than insulin, without a prescription; provided, however, that Eligible Expenses does not include "qualified long-term care services" as defined in Code Section 7702B(c).

b) In addition, an Eligible Employee may receive a Qualified Reservist Distribution if: (i) the Eligible Employee was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period; (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call; and (iii) is not made based on an order or call to active duty of any individual other than the Eligible Employee or for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Company shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made, and the provisions re: Qualified Reservist Distributions shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

6.5 Forfeitures and Transfers. Amounts may not be transferred between Eligible Employees' FSAs. Any balance remaining in an Eligible Employee's FSA at the end of any Plan Year shall be forfeited and shall remain the property of the Company. Notwithstanding the foregoing, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period, which commences on the first day of the subsequent Plan Year and shall end on the fifteenth day of the third calendar month of the subsequent Plan Year. See Schedule B to this Plan for

temporary rules extending the grace periods applicable to 2020 and 2021 contributions. Any unused contributions remaining in an Eligible Employee's FSA at the end of a Plan Year: (i) may only be used to reimburse expenses incurred with respect to that particular FSA; (ii) may not be cashed-out or converted to any other taxable or nontaxable benefit; (iii) that exceed the expenses incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and shall be forfeited. This Section is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

6.6 Nondiscrimination Requirements. It is the intent of this FSA not to discriminate in violation of the Code and the Treasury regulations thereunder. If the Administrator deems it necessary to avoid discrimination under this FSA, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

6.7 Reimbursement.

(a) *Documentation*. An Eligible Employee or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Claim Administrator. Any such claim shall include all information and evidence that the Claim Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Claim Administrator may request any additional information necessary to evaluate the claim.

(b) *Payment*. To the extent that the Claim Administrator approves the claim, the Company shall: (i) reimburse the Claimant, or (ii) at the option of the Claim Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Claim Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Claim Administrator may provide that payments/reimbursements of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(c) *Form of Claim/Notice*. All claims and notices shall be made in written form unless the Claim Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(d) *Refunds/Indemnification*. If the Claim Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Claim Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Claim Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Company for any liability the Company may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator or the Claim Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(e) *Debit, Credit or Other Stored Value Cards*. The Claims Administrator shall provide Eligible Employees with a debit, credit or other stored value card to provide immediate payment of reimbursements; provided, however that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits of the FSA without the use of the card.

(f) *Claim Administrator Procedures*. The Claim Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not

violate ERISA section. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year. In addition, if any amount paid is determined not to qualify as an Eligible Expense, the Company, in its discretion, may use one of the following correction methods to make the Plan whole: (a) repayment of the improper amount by you; (b) withholding the improper payment from your wages or other compensation to the extent consistent with applicable federal or state law; (c) claims substitution or offset of future claims until the amount is repaid; and (d) until the amount is repaid, take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the debit card.

SECTION 7. ADMINISTRATION OF PLAN – IN GENERAL.

7.1 Powers and Duties. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Administrator is responsible for the general administration of the Plan, and, to the extent that ERISA applies to this Plan, is the "Named Fiduciary" and "Plan Administrator" of the Plan for purposes of ERISA. The Administrator has full and unfettered discretionary power to administer the Plan in all respects, subject to the provisions of this Plan and the applicable requirements of law. In addition to all other powers provided by this Plan, the Administrator has full and unfettered discretion: (i) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan; (ii) to interpret the Plan; (iii) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan; (iv) to take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with any law, including modifying elections of highly compensated employees (as defined by the Code) without their consent; (v) to appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and (vi) to delegate its responsibilities under the Plan and to designate other persons or entities to carry out any of its responsibilities under the Plan. Notwithstanding the foregoing, the Administrator's authority under this Section shall not extend to any claim which arises under any program identified on **Schedule A** that is subject to a Claims Administrator or third-party insurer, other than a claim as to whether the individual satisfies the Company's requirements to be eligible to participate in the program. See Section 9.

7.2 Non-Discrimination Requirements. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment. In addition, it is the intent of this Plan to provide benefits to a class of employees which the Secretary of the Treasury finds not to be discriminatory in a manner proscribed under Section 125 of the Code, and to satisfy the nondiscrimination provisions of Section 125 of the Code with regard to Key Employees. If the Administrator deems it necessary to avoid discrimination or possible taxation to participants, it may, but shall not be required to, reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. In addition, the Company may designate one or more Qualified Benefit programs as constituting separate plans for purposes of satisfying the requirements under Section 105(h) of the Internal Revenue Code of 1986, as amended.

7.3 Examination of Records. The Administrator will make available to each participant such of its records under the Plan as pertain to the participant, for examination at reasonable times during normal business hours; *provided, however*, the Administrator shall not disclose records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature, except as required by law.

7.4 Reliance on Third Party Information. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the insurers or administrators of the plans by law any employee or former employee serving as the Administrator or as a member of a committee designated as Administrator against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

7.5 Subrogation and Third-Party Liability; Obligation to Reimburse Plan**.** If a participant or beneficiary is injured or ill and a third party is found liable, that third party will be liable for any expenses incurred by the Plan as a result of the injury. The participant or beneficiary shall be responsible for reimbursing the Plan, in first priority, for the applicable expenses paid by it and to cooperate fully to perform all actions necessary to secure the Plan's rights of recovery. If payment by a third party is made or is expected to be made in the future, the Plan will process claims and will seek reimbursement of funds through the recovery process from either the participant/beneficiary, the person(s) responsible for the injury and/or that person's insurer.

7.6 Right to Recover Benefit Overpayments and Other Erroneous Payments**.** To the extent permitted by law, if, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a participant or a beneficiary, the participant or the beneficiary shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, the third party administrator, the Administrator or the Company (or designee) may recover that incorrect payment, whether or not it was made due to the insurance companies', third party administrator's or the Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

7.7 Coordination of Benefits. If an individual claiming benefits under the Plan and/or any Qualified Benefit is covered under two or more plans (including the Plan and/or a Qualified Benefit program) then, unless otherwise provided in the Benefit Document, the order shall be determined as follows:

a) A plan that has no coordination of benefits provision will always be deemed to have primary benefit payment responsibility.

b) The plan covering the individual as an employee pays benefits first. The plan covering the individual as a dependent pays benefits second.

c) If no plan is determined to have primary benefit payment responsibility under subsection (b), then the plan that has covered the individual for the longest period has the primary responsibility.

d) Except as otherwise provided in subsection (e), the plan covering the parent of an eligible dependent pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The plan covering the parent of an eligible dependent pays second if the parent's birthday falls later in the year. If both parents have the same birthday, the plan covering the parent for the longest period of time shall be considered the primary plan with regard to a dependent Child. If the other plan does not follow the birthday rule, the other plan's coordination of benefits rule shall apply.

e) In the event that the parents of the eligible dependent are divorced or separated, the following order of benefit determination applies:

i. The plan covering the parent with custody of the eligible dependent pays benefits first.

ii. If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.

iii. If the parent with custody has remarried, then the plan covering the stepparent pays benefits second and the plan covering the parent without custody pays benefits third.

iv. However, if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first. If the court decree provides that the parents share joint responsibility, without assigning primary responsibility for healthcare, the birthday rule shall apply.

f) The plan covering an individual as an employee (or as the employee's dependent) who is neither laid-off nor retired pays benefits first. The plan covering that individual as a laid-off or retired employee (or as that individual's dependent) pays benefits second.

g) The plan covering an individual as an employee (or as a dependent of the employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another plan, and such other plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any individual who is provided COBRA continuation under this Plan and who also is covered simultaneously under another plan as an employee (or as a dependent of an employee). In the event of conflicting coordination provisions between this Plan and any other plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

h) Payments for benefits under the Plan to individuals who are eligible for Medicare Part A or Part B will be reduced by any payments for the same benefits under Medicare. The reduction is the amount payable by Medicare whether or not the payment is actually made. Consequently, the payment for any benefits under the Plan will be determined by the applicable Claims Administrator, and then reduced by the amount payable by Medicare. Coordination of Plan benefits with Medicare shall be determined in accordance with applicable Federal regulations describing the order of benefit determination with respect to primary and secondary coverage.

7.8 Unclaimed Benefits. Except as otherwise specified in a Benefit Document, in the event a benefits check issued by the Claims Administrator under a self-funded Qualified Benefit remains uncashed after one (1) year, the check will be voided and the funds forfeited and used at the Company's discretion to pay expenses of the Plan, including, without limitation, benefit and administration expenses. In the event the participant or the participant's beneficiary (as defined under ERISA) subsequently requests payment with respect to the voided check, the Claims Administrator or Administrator for the applicable Qualified Benefit will make such payment under the terms and conditions of that Qualified Benefit program as in effect when the claim was originally presented. However, any unclaimed benefits paid from a trust or insurance policy or contract funding the Plan or a Qualified Benefit shall be subject to the terms of the respective trust or insurance contract or policy.

7.9 No Assignment of Benefits. Plan benefits may not be assigned, alienated, or transferred in any way, and any attempt to do so is invalid and void. The Plan may choose to pay a benefit directly to the provider of health services or supplies, but no person covered by the Plan may assign to such provider his or her right to file a claim, appeal or legal action regarding Plan benefits. Participants may authorize a representative

to file a claim or an administrative appeal on their behalf, on a form provided by the Plan, but any such authorization may not include an assignment of the claim for the benefit.

SECTION 8. ADMINISTRATION, CLAIMS, AND APPEALS RELATING TO THE CAFETERIA PLAN.

8.1 In General. This Section outlines the general claim and appeal procedures that apply to claims under the cafeteria plan, such as whether a participant is an Eligible Employee, whether an election was timely made, and whether a participant is entitled to a special enrollment period due to a change in status. This Section does not apply to claims for Qualified Benefits. To file a claim for Qualified Benefits, see Section 9 and the specific claim and appeal procedures described in each Benefit Document listed in **Schedule A**.

8.2 Claims under this Cafeteria Plan. A participant, beneficiary, or an authorized representative may file claims with the Administrator. An "authorized representative" is a person authorized by the participant in writing to act on his or her behalf. If a claim is denied, the Administrator will notify the claimant of such denial in writing within 90 days, or within 180 days if the Administrator notifies the claimant in writing that special circumstances require additional time for processing the claim. The notice will: (i) explain the reason for the denial; (ii) refer to the pertinent Plan provisions on which the denial is based; (iii) describe any additional material necessary to perfect the claim and explain why such material is necessary; and (iv) explain the steps to be taken if the claimant wishes to submit the claim for review.

8.3 Appeals under this Cafeteria Plan. A claimant (or his or her duly authorized representative) may appeal the denial of a claim by filing a written appeal with the Administrator within 60 days of the original denial. The appeal must contain: (i) the date on which the original claim was filed; (ii) the specific portions of the denial the claimant wishes the Administrator to review; (iii) a statement setting forth the reasons the denial should be reversed; and (iv) any written material the claimant wishes the Administrator to examine when reconsidering the claim. The Administrator will permit the claimant to examine any documents that are relevant to his or her claim, subject to the restrictions of applicable law, including privacy laws.

8.4 Decisions on Appeal re: the Cafeteria Plan. The Administrator will notify the claimant of its decision on the appeal in writing within 60 days, or within 180 days if the Administrator notifies the claimant in writing that special circumstances require additional time for reviewing the appeal. The Administrator's final written decision will include: (i) specific reasons for the decision; (ii) specific references to the pertinent Plan provisions on which the decision is based; and (iii) an explanation of rights under ERISA's claims and appeals rules, if applicable. Any such decision will be final and binding.

8.5 Judicial Review of Appeals re: the Cafeteria Plan. After receiving a final appeal decision, the claimant will have exhausted his or her administrative remedies under the Plan, and may have a right to bring an action for benefits under ERISA Section 502(a)(1)(B), if the benefits are subject to ERISA. If any judicial or administrative proceeding is undertaken, it must be filed within 180 days after the date of the final appeal by the Administrator, and the evidence presented will be strictly limited to the evidence timely presented to the Administrator.

SECTION 9. ADMINISTRATION, CLAIMS, AND APPEALS RELATING TO QUALIFIED BENEFITS.

9.1 Coordination with Insurers. For certain Qualified Benefits the Company has purchased insurance contracts from the insurance companies listed on **Schedule A** (the "Insurers"). Claims for benefits are paid from the Insurers' assets. The Insurers have full discretion and authority to interpret and administer the Qualified Benefits, including the final and binding authority to make all determinations related to eligibility, claims, and appeals. Qualified Benefits will be paid only if the applicable Insurer determines in its discretion that the applicant is entitled to them.

9.2 Claims and Appeals re: Qualified Benefits. All claims should be filed directly with the applicable Insurer or Claims Administrator listed on **Schedule A** and will be processed by such Insurer or Claims Administrator in accordance with its procedures. However, in the event a Benefit Document does not

contain a claims procedure, or if ERISA requires the Insurer to comply with additional claim rules and such rules and/or rights are not reflected in a Benefit Document's claims procedure, the claims and appeals rights and rules detailed in Department of Labor regulations, including but not limited to 29 CFR §§ 2560.503-1 and 2590.715-2719, shall apply.

9.3 Restrictions on Insurers and Claims Administrators. Regardless of the terms of an Benefit Document, no Insurer or Claims Administrator may require a participant or beneficiary to do any of the following: (a) submit to binding arbitration or to binding mediation; (b) take the position that, by virtue of becoming covered under the insurance policy, rights to sue, including any "constitutional rights" or any "ERISA rights", are forfeited or waived; (c) require payment for any internal grievance or appeal procedure; (d) require more than two levels of appeal following the initial denial of a claim for benefits; or (e) require acceptance of the decision of an independent reviewer on an appeal of a denied claim.

9.4 Judicial Review of Appeals re: Qualified Benefits. After receiving a final appeal decision, the claimant will have exhausted his or her administrative remedies under the Plan, and may have a right to bring an action for benefits under ERISA Section 502(a)(1)(B), if the benefits are subject to ERISA. If any judicial or administrative proceeding is undertaken, it must be filed within 180 days after the date of the final appeal by the Insurer or Claims Administrator, and the evidence presented will be strictly limited to the evidence timely presented to the Insurer or Claims Administrator.

9.5 State Regulation. All Insurers are subject to state regulations. If a participant has a complaint about an Insurer, he or she can contact the state insurance department listed in the applicable Benefit Document, as well as pursue any remedy in the ERISA rights explanation.

SECTION 10. AMENDMENT AND TERMINATION OF THE PLAN.

10.1 Amendment of Plan. The Company reserves the power to amend the provisions of the Plan at any time, to any extent that it may deem advisable. Any amendment to the Plan shall be effected by a written instrument signed by the Company or an authorized delegate.

10.2 Termination of Plan. The Company has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but has no obligation whatsoever to maintain the Plan for any given length of time. The Company may discontinue or terminate the Plan at any time without liability by a written instrument signed by the Company or an authorized delegate.

SECTION 11. COMPLIANCE WITH FEDERAL LAWS AFFECTING QUALIFIED BENEFITS.

11.1 Women's Health & Cancer Rights Act. As required by the Women's Health and Cancer Rights Act of 1998, the Plan will provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

11.2 No Discrimination based on Genetic Information or Specified Health Status Factors. In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan, the Administrator, the Company or any Claim Administrator or Insurer discriminate against a participant or an eligible Dependent on the basis of genetic information with respect to eligibility, premiums and contributions. The Plan will not collect (i.e., request, require, or purchase) genetic information for underwriting purposes. The Plan will not collect participants' or dependents' genetic information before the effective date of coverage or in determining an individual's eligibility to participate in the Plan. In no event shall the Plan, the Administrator, the Company or any Claims Administrator or Insurer discriminate against any participant or eligible dependent with regard to eligibility, premiums or contributions based on specified health status-related factors. The Plan will not request or require any participant or his or her family member to undergo a genetic test.

11.3 Newborns' and Mothers' Health Protection Act of 1996. The Plan shall comply with the requirements of

the Newborns' and Mothers' Health Protection Act of 1996, which mandates minimum length of hospital confinement in connection with childbirth.

11.4 HIPAA Privacy Requirements. Solely with respect to group health plan benefits provided under this Plan that are subject to the privacy rules and security rules under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan shall comply with HIPAA. The Company shall maintain adequate separation between the Plan and the Company as sponsor of the Plan, supported by reasonable and appropriate security measures. Only the following employees, acting on behalf of the Company as sponsor of the Plan, may have access to protected health information under HIPAA in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to administration of, the Plan: the Director, Compensation and Benefits (who is the Plan's Privacy Officer for HIPAA purposes) and the Benefits Specialist.

SECTION 12. STATEMENT OF ERISA RIGHTS

Each participant in a plan providing Qualified Benefits that are subject to ERISA is entitled to certain rights and protections under ERISA, including the following:

12.1 Receive Information about the Plan and Benefits. Participants may examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing ERISA plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Participants also may obtain, upon written request to the Administrator, copies of documents governing the operation of ERISA plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan document, but the Administrator may make a reasonable charge for the copies. Each participant also is entitled to a copy of a summary annual report.

12.2 Continue Group Health Plan Coverage. Participants may continue health care coverage for themselves, their Spouse, or their dependents if there is a loss of coverage under a group health plan as a result of a Qualifying Event. See Section 3.4 of this Plan, and the provisions of the Benefit Documents for any group health plan benefits listed in **Schedule A**, for additional information.

12.3 Reduce or Eliminate Pre-Existing Condition Exclusions. Participants should be provided a certificate of creditable coverage, free of charge, from a group health plan or health insurance issuer when they lose coverage, become entitled to elect COBRA continuation coverage, or when COBRA continuation coverage ceases, or upon request before losing coverage or up to 24 months after losing coverage.

12.4 Prudent Actions by Plan Fiduciaries. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the ERISA plans. The people who operate ERISA plans, called "fiduciaries", have a duty to do so prudently and in the interest of participants and beneficiaries. No one, including the Company, your union, or any other person, may fire or otherwise discriminate against individuals in any way to prevent them from obtaining benefits or exercising rights under ERISA.

12.5 Enforce Legal Rights. If a participant's claim for a welfare benefit is denied or ignored, in whole or in part, s/he has 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 to take to enforce these rights. For instance, if a participant requests a copy of plan documents or the latest annual report from the Plan and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the 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 a participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or Federal court. In addition, if a participant disagrees with an ERISA plan's decision or lack thereof concerning the qualified status of a medical child support order,

s//he may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if a person is discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the claim is frivolous. No action at law or in equity may be brought to recover under the Plan until the appeal rights provided have been exercised and the benefits requested in such appeal have been denied in whole or in part.

12.6 Assistance with Questions. Participants with any questions about the Plan should contact the Administrator. Participants with any questions about this statement or about rights under ERISA, or who need assistance in obtaining documents from the Administrator, should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or contact 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. Participants may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 13. MISCELLANEOUS PROVISIONS.

13.1 Information to be Furnished. Participants shall provide the Company and the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

13.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Eligible Employee or participant or other person any legal or equitable right against the Company or the Administrator, except as provided herein.

13.3 Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any individual any right to be retained in the employ of the Company.

13.4 Governing Law. Except to the extent federal law applies, this Plan shall be construed, administered. and enforced according to the laws of the State of Rhode Island.

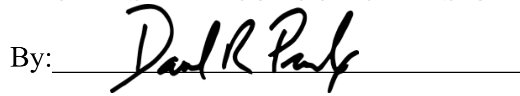
13.5 No Guarantee of Tax Consequences. This Plan is intended to permit Eligible Employees, where permitted by law, to pay for Qualified Benefits on a pre-tax basis. However, neither the Company nor the Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any participant. Each participant must determine whether each payment under the Plan is excludable from the participant's gross income for federal and state income tax purposes, and to notify the Company if the participant has reason to believe that any such payment is not so excludable.

13.6 QMCSO Procedures. The Administrator has the responsibility to determine whether a medical child support order is a "qualified medical child support order" under the terms of ERISA, though the Administrator may delegate this responsibility to one or more of the Company's officers or employees, or one or more other persons, including the applicable insurance company or third party administrator. The Plan's QMCSO procedures are available from the Administrator.

13.7 Experience Rebates. To the extent any Qualified Benefit program generates Medical Loss Ratio or other rebates, those rebates shall be attributed to the Company's share of the premiums (or premium equivalents) and shall not be considered Plan assets attributable to employee premium contributions, except to the extent otherwise required by ERISA or other applicable law

IN WITNESS WHEREOF, the Company has caused this Plan to be executed in its name and behalf by a duly authorized delegate effective this 24th day of February, 2022.

RHODE ISLAND SCHOOL OF DESIGN

By: 

Title: Interim President & Sr. Vice President Finance & Administration

SCHEDULE A

All Benefits offered under this Plan are offered through, and subject to the terms and conditions of, an insurance contract. In addition, these benefits are subject to applicable RISD policy and, for employees in a bargaining unit, the terms and conditions of the collective bargaining agreement by and between Rhode Island School of Design and the employee organization.		
Pre – Tax Benefits		
Benefit	**Insurer/Claims Administrator**	**Funding Method**
▪ **Medical** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Full-time faculty and professional librarians] [Only available to part-time faculty if they (a) agree to a 12-month payment schedule and (b) are members of the bargaining unit]	**Blue Cross & Blue Shield of Rhode Island (Claims Administrator)** 500 Exchange Street Providence RI 02903 (401) 459-5000 Outside Rhode Island: 1-800-639-2227 TDD: 1-888-252-5051	Self -insured Employer and employee contributions
▪ **Prescription Drug** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Full-time faculty and professional librarians] [Only available to part-time faculty if they (a) agree to a 12-month payment schedule and (b) are members of the bargaining unit]	**CVS Caremark Claims Department (Pharmacy Benefit Manager/Claims Administrator)** P.O. Box 52136 Phoenix, AZ 85072-2136 (833) 987-2818	Self -insured Employer and employee contributions
▪ **Dental** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Full-time faculty and professional librarians] [Only available to part-time faculty if they (a) agree to a 12-month payment schedule and (b) are members of the bargaining unit]	**Delta Dental of Rhode Island (Insurer)** P.O. Box 1517 Providence, RI 02901-1517 (800) 843-3582	Insured Employer and employee contributions
▪ **Vision** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Not available to full-time faculty or professional librarians, or part-time faculty]	**Davis Vision (Insurer)** Capital Region Health Park, Suite 301 711 Troy-Schenectady Road Latham, New York 12110 (800) 999-5431	Fully-insured Employee contributions
▪ **Health Flexible Spending Account** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Full-time faculty and professional librarians]	**Benefit Strategies, LLC (Claims Administrator)** PO Box 1300 Manchester, NH 03105 (888) 401-3539	Self-funded Employer and employee contributions
After-Tax Benefits		
Benefit	**Insurer/Claims Administrator**	**Funding Method**
▪ **Basic Life Insurance** ▪ **Accidental Death and Dismemberment Insurance** [Staff, full-time faculty and professional librarians that are budgeted to work at least 17.5 hours per week and 910 hours per year] [Not available to part-time faculty unless in grandfathered status]	**Standard Insurance Company (Insurer)** 401 Edgewater Place, suite 520 Wakefield MA 01880	Fully-insured 100% employer funded
▪ **Short-Term Disability** [Staff budgeted to work at least 17.5 hours per week and 910 hours per year] [Not available to full-time faculty or professional librarians or part-time faculty]	**Lincoln Financial Group (Claims Administrator)** 150 North Radnor Chester Rd. Radnor, PA 19087	Self-funded 100% employer funded

▪ **Long-Term Disability** [Staff, full-time faculty, and professional librarians budgeted to work at least 30 hours per week and 1560 per year] [Part-time faculty in the bargaining unit are eligible, but pay 100% of the cost]	**Lincoln Financial Group (Insurer)** 150 North Radnor Chester Rd. Radnor, PA 19087	Fully-insured Employer and employee contributions
▪ **Employee Assistance Plan** [Full- or part-time employees, and COBRA beneficiaries, including up to 60 days post-termination or resignation]	**Coastline EAP (Insurer)** 300 Centerville Road, Suite 301 South Warwick, RI 02886 1-800-445-1195	Fully-insured 100% employer funded

Benefit Documents

This Plan should be read in combination with the insurance documents, benefit summaries, and other evidence of coverage documents (together and individually referred to as "Benefit Documents") provided by the insurers and Claims Administrators. Benefit Documents describe the Qualified Benefits, and when read together with this Plan, applicable RISD Policy, and, to the extent applicable, the terms and conditions of a collective bargaining agreement, are intended to meet ERISA's SPD requirements. For additional information or for copies of the Benefit Documents, please contact the Administrator.	
Medical	• RISD Full-Time Faculty Standard Plan - Blue Cross & Blue Shield of Rhode Island/HealthMate Coast to Coast 100/80 No Deductible • RISD Full-Time Faculty Deductible Plan - Blue Cross & Blue Shield of Rhode Island /HealthMate Coast to Coast 100/80 $250 Coinsurance • RISD Full-Time Faculty PPO Plan - Blue Cross & Blue Shield of Rhode Island /HealthMate PPO • RISD Staff and Part-Time Faculty Standard Plan (High Premium/Low Deductible Plan) - Blue Cross & Blue Shield of Rhode Island /HealthMate Coast to Coast 100/80 $250 Coinsurance • RISD Staff Mid Premium/Mid Deductible Plan - Blue Cross & Blue Shield of Rhode Island/HealthMate Coast-to-Coast 90/70 $500 Coinsurance • RISD Staff Low Premium/High Deductible Plan - Blue Cross & Blue Shield of Rhode Island/Blue Solutions $1,500 $3,000 High Deductible Health Plan (HSA Qualifying)
Prescription Drug	• RISD Prescription Drug Plan – CVS Caremark Benefits (as applicable to Medical Plan options listed above)
Dental	• RISD Staff Premier Plan Plus - Delta Dental of Rhode Island • RISD Staff Premier Plan - Delta Dental of Rhode Island • RISD Faculty Premier Plan - Delta Dental of Rhode Island
Vision	Davis Vision/Premier Plan
Group Life and AD&D	The Standard Group/ Life Insurance, Accidental Death & Dismemberment, and Dependent Life Insurance[1]
Short-term disability	Liberty Life Assurance Company of Boston Group /Supplemental Short Term Disability Insurance
Long-term disability	Liberty Life Assurance Company of Boston Group/Long Term Disability Insurance Liberty ERISA SPD Update April 1, 2018
Employee Assistance Plan	Coastline EAP Brochure

[1] Only Basic Life Insurance is covered under this Plan; Supplemental Life and Dependent Life are not permitted to be covered under the Plan under applicable law.

SCHEDULE B

Pursuant to the Consolidated Appropriations Act, 2021, temporary rules applicable under the Health Care FSA are available to Eligible Employees. See below.

1. For contributions made in 2020 and 2021, the grace period described in Section 6.5 shall commence on the first day of the subsequent Plan Year and shall end on December 31st of that Plan Year.
2. For the 2021 Plan Year Eligible Employees may make prospective mid-year election changes to increase or decrease existing elections. An election to increase a contribution amount is subject to the annual IRS limit on contributions. An election to decrease a contribution amount cannot reduce an account balance to less than what has already been contributed year to date and/or whatever has been paid out in claims reimbursements, whichever is greater. Log onto your Workday account to make election changes. For more information, please contact Marissa McNally at mmcnally@risd.edu or Cathy Davis at cdavis@risd.edu.