The New School

Flexible Spending Account

SUMMARY PLAN DESCRIPTION

Effective January 1, 2021

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INTRODUCTION

This Summary Plan Description (SPD) describes the Flexible Spending Account benefits provided by The New School Cafeteria Plan (the Plan) for eligible employees and their eligible dependents.

The New School reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, The New School has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by The New School or to interfere with The New School's right to discharge any employee at any time. Providing this SPD to you does not entitle you to benefits for which you are otherwise not eligible.

ELIGIBILITY

ELIGIBLE EMPLOYEES

Generally, you are considered an "eligible employee" if you are regularly scheduled to work at least 20 hours-per-week or more (unless you are part-time faculty and your collective bargaining agreement specifies a different minimum number of hours). You are eligible to participate in the Plan on the first of the month following 30 days of employment in a benefits eligible position, or as otherwise provided in a collective bargaining agreement.

Individuals Not Eligible for Plan Benefits

You are not eligible to participate in the Plan if you are classified by your employer as:

- Regularly scheduled to work fewer than 20 hours per week, or as otherwise specified in your collective bargaining agreement if applicable;
- A seasonal or temporary employee;
- A leased employee;
- An independent contractor;
- A nonresident alien who receives no US source income (within the meaning of the Code) from The New School; or
- A member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

Eligibility Determinations Are Made by The New School

It is solely within the authority of the Plan Administrator to determine whether you are eligible for Plan benefits. A person whom the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee. A person the Plan Administrator determines is not an employee and who is later required to be reclassified as an employee will only be eligible prospectively, provided all other eligibility requirements are met.

ELIGIBLE DEPENDENTS

Health Care Flexible Spending Account

For purposes of the Health Care Flexible Spending Account, your dependents are:

- Your spouse, which means a person recognized as married to you by the state, possession or territory of the United States in which you were married, regardless of where you live;
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession or territory of the United States, regardless of where you live;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support; and
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

Dependent Care Flexible Spending Account

Under IRS regulations, "eligible dependents" for the Dependent Care Flexible Spending Account include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code);
- A disabled spouse who lives with you for more than one half the year; and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and is not the qualifying child of the employee or any other individual.

You Must Notify the Plan of Certain Events Regarding Your Dependents

If you experience a change in status event, and you want to change your dependent coverage as a result (see the *Making Changes to your Coverage During the Year* section of this SPD), you must notify The New School within 31 days in order to make a change in your election during the year. The notice must be done online through MyDay and contain the change in status event, the date of the event, and your requested change . You must attach all supporting documentation for the type of event and the date of the event.

ENROLLMENT

NEW EMPLOYEES

If you are an eligible employee (as defined in the *Eligibility* section of this SPD), you must affirmatively enroll yourself and your eligible dependents within 30 days of your eligibility date for the following Flexible Spending Accounts:

- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

What Happens if You Don't Enroll When You Are First Eligible?

If you and your eligible dependents do not enroll in Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverages within 30 days of your eligibility date, you will have to wait until the next Open Enrollment period to enroll, unless you experience a change in status event (see *Making Changes to Your Coverage During the Year* section of this SPD).

When Does Coverage Begin?

Your coverage under the Plan will begin on the first of the month following your enrollment (or if later, the date you are eligible).

If you enroll yourself or a dependent in the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account benefits mid-year due to a change in status, coverage will be effective as of the first of the month following the date the Plan receives your timely request for enrollment due to a change in status.

Open Enrollment for Current Employees

Open Enrollment is held before the start of the Plan Year. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You will receive information, including instructions on how to enroll, before Open Enrollment each year.

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

Contributions to the Health Care and Dependent Care Flexible Spending Account are on **a pre-tax basis**. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. If you are enrolled in the high deductible health plan you may make pre-tax contributions to a Health Savings Account.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment remain in effect for the following plan year (January 1 through December 31), except as described in this section.

Changes in Status

Flexible Spending Account Mid-Year Changes

You may be able to change your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account elections during the Plan Year if you experience a change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify The New School within 31 days of the event, or 60 days for changes related to losing eligibility for Medicaid or CHIP coverage or gaining eligibility for a state's premium assistance program (see the *HIPAA Special Enrollment Events* section). If you do not notify The New School within the 31-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree, etc.). The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area;
- **FMLA leave:** Beginning or returning from an unpaid FMLA leave.

Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy this "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent children who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child. You may not cancel coverage for yourself or other covered dependents.

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Health Care Flexible Spending Account elections.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases or decreases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or
- You make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact Human Resources at The New School.

FMLA LEAVE

The federal Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty or call to active duty in the Armed Forces or a military reserve unit from the National Guard, Military Reserve or retired status in the Armed Forces or Reserve. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty.

If you take an FMLA leave, you may continue your Health Care Flexible Spending Account coverage. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you make contributions for your FSAs by catching up with pre-tax

contributions upon your return from leave. You also have the option to suspend your Health Care Flexible Spending Account coverage during the leave.

If your Health Care Flexible Spending Account coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care Flexible Spending Account coverage amount.)

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see the *COBRA* section of this SPD).

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Health Care Flexible Spending Account coverage for up to 24 months as long as you give The New School advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from The New School, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

Participation in the Dependent Care Flexible Spending Account will terminate.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at The New School, you will be treated as if you had been actively employed during your leave when determining whether an exclusion

or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see the *COBRA* section of this SPD). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See *COBRA* section of this SPD) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, by termination of the insurance contract or agreement, or by discontinuance of contributions by The New School;
- The end of the month in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage due to certain specified situations.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

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 public Marketplace. 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 30-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 Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to The New School, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of The New School, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualified events:

- A reduction in your hours of employment with The New School, or
- The termination of your employment with The New School (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of The New School, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with The New School (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with The New School; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualified events:

- The death of the parent-employee;

- The termination of the parent-employee's employment with The New School (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform The New School that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify The New School of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify The New School (see Contact Information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if The New School requests it. Acceptable documentation includes a copy of the divorce decree or dependent child's birth certificate(s), or driver's license.

You must mail or hand deliver this notice to The New School at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to The New School within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to The New School.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). When you complete the election form, you must notify The New School if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care Flexible Spending Account COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care Flexible Spending Account by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium. See “Duration of COBRA,” below, for a description of the duration of COBRA coverage for the Health Care Flexible Spending Account.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, ACH debit or on-line credit card payment, as permitted by The New School. Your first payment and all monthly payments for COBRA coverage must be submitted on-line, mailed or hand delivered to The New School.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact The New School to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. Notwithstanding the previous sentence, a Qualified Beneficiary shall carryover any amounts described in the *Health Care Flexible Spending Account* section of this SPD at the end of the Plan Year, to a subsequent Plan Year. The carryover shall only be available for the duration of the period of COBRA continuation coverage. No premium will be charged for the subsequent Plan Year.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the maximum period for any of the following five reasons:

- The New School no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee), but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied;
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, The New School reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

COBRA Administrator:
EBPA
1-888-678-3457
P.O. Box 1140
Exeter, NH 03833-1140

Plan Administrator:
The New School
80 5th Avenue, 8th floor, New York, NY 10011
212-229-5671

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Health Care Flexible Spending Account may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage.

This section explains how the Health Care Flexible Spending Account allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive a portion of what would otherwise be your regular pay in health care expense reimbursement. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the *Eligible Dependents* section of this SPD.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not less than $100 and not more than $2,750 (or the amount communicated annually by The New School), per Plan Year of your own money to your Health Care Flexible Spending Account.

ELIGIBLE EXPENSES

The Health Care Flexible Spending Account is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, coinsurance, copayments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except menstrual care products, smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses that may be eligible for reimbursement under the Health Care Flexible Spending Account:

- Medical Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "reasonable and customary" limits
  - Expenses excluded under the terms of the Medical benefit plan
  - Menstrual care products
  - Personal protective equipment for the primary purpose of preventing the spread of the Coronavirus Disease 2019
  - Drugs requiring a doctor's written prescription that are not covered the Medical benefit plan
  - Over-the-counter drugs as permitted under applicable law or regulation
  - Smoking cessation programs and related medicines
  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by a medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches)
- Dental Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic

- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by a vision plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

INELIGIBLE EXPENSES

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care Flexible Spending Account:

- Premiums
  - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense. This exclusion does not include menstrual care products or PPE.
- Long term care expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care Flexible Spending Account.

These are general examples of reimbursable expenses and ineligible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

USE OR LOSE

IRS regulations stipulate that you must use the full amount of money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year, or forfeit what remains. Your request for reimbursement must be filed by the deadline in the *Filing a Claim* section below. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

If you have a balance left in your Health Care Flexible Spending Account after the claim run out period, you may carryover up to $550 of any remaining balance. This amount may be increased annually, as permitted under IRS rules and as communicated annually by The New School. If you have less than the

maximum permissible carryover amount remaining, you may carryover up to the amount of your unused balance. The unused balance cannot be cashed out. Any amounts in excess of the maximum permissible carryover amount will be forfeited

For the end of the 2020 and 2021 Plan Years only, you are not limited to $550, but may carryover the entire unused balance into the following Plan Year. The unused balance cannot be cashed out.

You may not use money in your Health Care Flexible Spending Account to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Unless you elect to continue your Health Care FSA coverage under COBRA (see *COBRA* section above), your Health Care FSA coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed from your Health Care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator by March 31 following the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Dependent Care Flexible Spending Account allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed in the *Eligible Dependents* section of this SPD.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not less than $100 and not more than $5,000 per Plan Year of your own money to the Dependent Care Flexible Spending Account.

The IRS limits the amount you may contribute to your Dependent Care Flexible Spending Account. There is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). But another limitation also applies. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During the calendar year, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care Flexible Spending Account will be limited to $3,600. She can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse’s actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse’s actual income (if any) or $500 a month.

ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Dependent Care Flexible Spending Account include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you’re married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

Ineligible Expenses

You cannot use the money in your Dependent Care Flexible Spending Account to pay for:

- General “baby-sitting” other than during work hours
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Flexible Spending Account.

Use or Lose

It is important that you not contribute more than the dependent care expenses that you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year, or forfeit what remains. You must incur eligible expenses by December 31 in order for them to be eligible for reimbursement. Your request for reimbursement must be filed by the deadline in the *Filing a Claim* section below. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

For the end of the 2020 and 2021 Plan Years only, if you have a balance left in your Dependent Care Flexible Spending Account after the claim run out period, you may carryover any remaining balance. The unused balance cannot be cashed out. After the end of the 2021 Plan Year, the Plan will not allow any carryover of unused Dependent Care Flexible Spending Account balances.

You may not use money in your Dependent Care Flexible Spending Account to pay health care expenses and vice versa. You may not switch money between the two accounts.

Filing a Claim

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a Plan Year must be submitted to the Claims Administrator by March 31st after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Only claims incurred on or before your date of termination may be reimbursed from your dependent care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator by March 31 following the end of the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

SPECIAL RULES AFFECTING DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Several special rules apply to Dependent Care Flexible Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care Flexible Spending Account. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care Flexible Spending Account. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Flexible Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child, you may be able to be reimbursed from the Dependent Care Flexible Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

CLAIMS AND APPEAL PROCESS

FILING A CLAIM

A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse or child) must submit a written request on a form approved by the Plan Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed below), a participant's or beneficiary's treating physician or other health care professional may act as an

authorized representative in exercising a participant's or beneficiary's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a participant's or beneficiary's behalf. Any attempted assignment of benefits by a participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the Plan.

Claims Administrators – Self-Insured Plan Benefits	
The Plan benefits listed below are self-insured. The New School has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.	
Flexible Spending Accounts	EBPA 1-888-678-3457 P.O. Box 1140 Exeter, NH 03833-1140

This section provides general information about the claims and appeals procedure applicable to certain Plan benefits under ERISA. (The *Administrative Information* section of this SPD identifies which Plan benefits are *not* subject to ERISA. These claims and appeals rules do not apply to those benefits.) Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information. **If there are any discrepancies between the claims and appeals procedures in this summary and the applicable Benefit Booklet, then the Benefit Booklet will govern.**

Claim-Related Definitions

Claim

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

INITIAL CLAIM DETERMINATION

For each of the Plan benefits, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

	HCFSA	DCFSA
Time frame for Providing Notice	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.
Extensions	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have at least 45 days to provide any missing information.	No rule.

	HCFSA	DCFSA
Other Related Notices	N/A	N/A
*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information		

APPEALING A CLAIM

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the *Filing a Claim* section of this SPD. If you don't appeal on time, you lose your right to later object to the decision.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the *Time Frames for Appeals Process* section of this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are 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 for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and

- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health benefit under the Plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The claim appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Health Care FSA	**Dependent Care FSA**
Period for Filing Appeal	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	Additional 60 days if special circumstances require extension.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plan or the right to assert legal or equitable rights, including an administrative claim, action under state law or lawsuit against any of the following: the Plan, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company and any Participating Employers, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plan to any other party, including any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction) or to bring any administrative claim, action under state law or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

MISSTATEMENTS AND MISREPRESENTATIONS

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Cafeteria Plan Name	The New School Cafeteria Plan
ERISA Plan Name	The New School Health and Welfare Plan
ERISA Plan Number	503
Plan Sponsor	The New School 80 5th Avenue, 8th floor, New York, NY 10011
Employer Identification Number	13-3297197
Plan Administrator	The New School 80 5th Avenue, 8th floor, New York, NY 10011 212-229-5671
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing benefits, including the following: ▪ Health Care Flexible Spending Account Although the Dependent Care Flexible Spending Account is described in this SPD, it is **not** an ERISA plan.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

The New School reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, The New School reserves the right to amend or terminate benefits, covered expenses, benefit coinsurance and copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. The New School also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by The New School will be done in accordance with The New School's normal operating procedures. Amendments will be effective at such date as The New School determines, or upon the date of execution or adoption if no effective date is given. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of The New School, the Plan shall terminate unless the Plan is continued by a successor to The New School.

If a benefit under the Plan is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to The New School to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If the entire Plan terminates, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses.

PLAN ADMINISTRATION

The New School is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. The New School has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and The New School will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor The New School will be liable in any manner for any determination made in good faith.

The New School may designate other organizations or persons to carry out specific fiduciary responsibilities for The New School in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The New School will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

ERISA

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

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest

annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent children if there is a loss of coverage under the Plan because 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer 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 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 (if any) 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:

Office of Outreach, Education, and Assistance
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.