Reimbursement Accounts

Effective 1 January 2020

Building a better working world

Contents

Introduction

Under the EY Flexible Benefits Program and the Dependent Day Care Plan (together, the Plan), eligible staff members may elect to participate in the Health Care or Limited Use Health Care and/or Dependent Day Care Reimbursement Accounts. If you participate in these accounts, you are reimbursed with before-tax dollars for eligible health care expenses and/or dependent day care expenses.

It is important that you understand the advantages — and the limitations — of reimbursement accounts before you decide whether to participate. Because of federal income tax rules, changes in your deposit amounts to your accounts are restricted as described on page 8. These tax rules also require that you forfeit any deposit amounts contributed to your reimbursement accounts but not spent. Therefore, you must estimate your deposit amounts carefully.

Complete information about the Plan is contained in the Plan documents. If a conflict exists between this summary and the Plan documents, the Plan documents will govern. Questions may be directed to the Better You Benefits Center.

This booklet summarizes information about the Reimbursement Accounts available to staff members of Ernst & Young US LLP (the firm), its participating joint ventures, participating affiliates and participating subsidiaries under the EY Flexible Benefits Program and the Dependent Day Care Plan (together, the Plan). Non-US subsidiaries of participating joint ventures, participating affiliates or participating subsidiaries are not considered to be participating joint ventures, participating affiliates or participating subsidiaries (and their respective employees and partners are not eligible to participate in the Program), unless they are specifically designated as participating joint ventures, participating affiliates or participating subsidiaries by Ernst & Young US LLP. Unless otherwise noted, the term "staff members" in this booklet refers to all personnel, excluding partners/principals. Partners/principals are not eligible for Reimbursement Accounts.

Staff members and beneficiaries may receive, upon written request to Total Rewards–Benefits, information as to whether a particular subsidiary participates in the Program and if so, the address of that employer.

All references to EY in the document are to Ernst & Young US LLP.

For answers to questions regarding coverage and eligibility, access Better You at http://digital.alight.com/ey or call the Better You Benefits Center at + 1 877 339 1239.

While the firm intends to continue the Plan, the firm reserves the right to amend or terminate the Plan at any time without prior notice, in any manner and with respect to any class of individuals.

Reimbursement accounts and forfeitures

How reimbursement accounts work

Reimbursement accounts work differently for health care and dependent day care.

For health care, you will need to estimate how much you will spend during the year on eligible health care expenses not covered by your medical, dental and/or vision plan in order to determine your annual deposit amount. The calendar-year amount you elect to deposit to your account will be available for reimbursement as of the first day of the month of your participation for that calendar year. For example, during the Annual Enrollment period, you elect to contribute $1,200 to your Health Care Reimbursement Account for the coming calendar year. You then incur an eligible expense equal to or less than your elected deposit amounts of $1,200 during your second month of participation. You can be reimbursed for the entire expense submitted even though your actual deposit amounts at the time the claim is submitted are less than the amount of your claim. Expenses must be incurred during your period of participation. For example, if your participation begins 1 February and ends 30 November of the calendar year, only expenses incurred from 1 February through 30 November are eligible for reimbursement.

For dependent day care, you again estimate how much you will spend during the coming calendar year on eligible dependent day care expenses and decide your semimonthly Dependent Day Care Reimbursement Account deposit amounts. Expenses must also be incurred during your period of participation which begins when contributions start and ends at the end of that calendar year. If your participation in the Dependent Day Care Reimbursement Account terminates, claims incurred through the end of the calendar year will be reimbursed to the extent that sufficient deposit amounts are available in your account. **Unlike the Health Care Reimbursement Account, only the actual deposit amounts contributed to your Dependent Day Care Account will be available for reimbursement.**

During the year, you file your claims for both health care and dependent day care expenses through your reimbursement account administrator, Your Spending Account (YSA). Expenses may be submitted to YSA as soon as they are incurred. Your Reimbursement Account checks are issued periodically and are sent to you at your home address. You also have the option to have your reimbursement deposited to your checking or savings account. Information about setting up direct deposit is available in the Reimbursement Accounts section of the Better You website. You may also choose to use a YSA Debit Card to pay for eligible health care expenses. As you use your card, eligible expenses will be automatically deducted from your account. You can request a YSA Debit Card via the Reimbursement Accounts section of the Better You website.

Direct submission

If you're enrolled in a medical, dental or eyewear plan with Anthem BlueCross BlueShield (with AmeriBen as claims processor), UnitedHealthcare, CVS/Caremark, MetLife or EyeMed and you elect to participate in the Health Care Reimbursement Account, all unreimbursed, eligible medical and dental claims submitted under your medical, dental or eyewear plan will be automatically forwarded to your Health Care Reimbursement Account with YSA for processing. This means that you'll receive reimbursement automatically for certain expenses from your Health Care Reimbursement Account without having to file a claim. All other eligible expenses should be submitted directly to YSA for reimbursement.

Forfeitures

Federal tax law requires that you forfeit any amounts remaining in your reimbursement accounts after all claims related to that calendar year have been processed. You have until 31 March to file claims for expenses incurred during the prior calendar year.

If your participation in the Health Care Reimbursement Account terminates, claims incurred in the same calendar year in which you make deposit amounts will be paid as they are submitted, provided they do not exceed your elected annual deposit amounts. When participation terminates, only eligible expenses incurred during your period of participation will be paid. However, you have until 31 March of the next year to file claims for expenses incurred during your period of participation.

If your participation in the Dependent Day Care Reimbursement Account terminates, claims incurred through the end of the calendar year will be reimbursed to the extent that sufficient deposit amounts are available in your account. You have until 31 March to file claims for expenses incurred during the prior calendar year.

If any deposit amounts in excess of $500 (as described below in "Health Care Reimbursement Account Rollover") remain in your Health Care Reimbursement Account after your reimbursement account administrator processes claims received by 31 March of the next year, the amounts will be forfeited. If any deposit amounts remain in your Dependent Day Care Reimbursement Account after your reimbursement account administrator processes claims received by 31 March of the next year, the amounts will be forfeited.

Forfeited deposit amounts will be used to defray the administrative costs of reimbursement accounts.

Limited use Health Care Reimbursement Account

If you are enrolled in the $2,500 deductible plan, you are eligible to participate in the Limited Use Health Care Reimbursement Account. Limited Use Health Care Reimbursement Accounts follow the same provisions as regular Health Care Reimbursement Accounts with the exception of eligible expenses, which are limited to dental and vision expenses.

Health Care Reimbursement Account Rollover

If you are enrolled in a Health Care or Limited Use Health Care Reimbursement Account, you may carry over up to $500 of your remaining balance to use the following plan year. The rollover amount will be in addition to any newly elected funding for the new plan year. Any unused amounts over $500 will be subject to the forfeiture provision described above and will not be rolled over.

The rollover provision does not apply to Dependent Day Care Reimbursement Accounts.

Planning, tax advantages and other considerations

Planning

Planning is the key to taking advantage of the tax effectiveness of reimbursement accounts. You will need to estimate the amount of your predictable health care and dependent day care expenses and determine your annual deposit amounts accordingly. You may find referring to last year's expenditures helpful.

Tax advantages

You receive the same tax advantages by paying expenses through reimbursement accounts as you do by paying medical, dental, eyewear, group term life insurance and AD&D premiums with before-tax dollars. Deposit amounts to reimbursement accounts are deducted from your salary before taxes are computed. You are taxed only on your remaining salary. The results are less taxable income and federal income taxes, possibly less Social Security tax and Medicare tax, and, in most locations, less state and local taxes.

Example

The example below illustrates the potential tax savings when you participate in reimbursement accounts. Your own tax savings will depend on your salary, Reimbursement Accounts deposit amounts and tax situation.

Eric is a full-time staff member and earns $85,000 a year, is married and has one child. Eric expects to incur $2,000 in eligible health care expenses for the calendar year. He elects the medical plan (Open Access Plan – Select) and the dental program, with coverage for himself, his spouse and one child.

	Without Health Care Reimbursement Account	With Health Care Reimbursement Account
Annual salary	$ 85,000	$ 85,000
Annual before-tax premiums	(5,589)	(5,589)
Before-tax deposit amounts for eligible health care expenses	0	(2,000)
Taxable salary	79,411	77,411
Federal income and Social Security taxes*	14,129	13,736
After-tax expenditures for eligible health care expenses	2,000	0
Spendable income	63,282	63,675
Annual tax savings	$ 0	$ 393

In this example, using before-tax dollars to pay for eligible health care expenses increases Eric's spendable income by $393 a year.

You can either be reimbursed for eligible expenses through your Reimbursement Accounts or, if you qualify, take a deduction for eligible health care expenses and/or dependent day care tax credit for the eligible dependent day care expenses on your federal income tax return. However, you cannot be reimbursed through your Reimbursement Accounts and also take a health care expense deduction or dependent day care tax credit for the same expenses.

The approach that produces the greater tax savings for you depends on your personal situation. Here are some general guidelines to keep in mind as you make your decisions.

- **Health care expenses**. If you do not itemize deductions on your federal income tax return or if your eligible health care expenses are less than 7.5% of your adjusted gross income, you will not qualify for a deduction on your federal income tax return for your eligible health care expenses. Therefore, it may be advantageous for you to use the Health Care Reimbursement Account and use before-tax dollars to pay for eligible health care expenses.
- **Dependent day care expenses**. If you have eligible dependent day care expenses, you may qualify for a dependent day care tax credit on your federal income tax return. You do not have to itemize deductions to qualify for the dependent day care tax credit.

Note that any expenses you use to qualify for the tax credit for dependent day care expenses are not eligible for reimbursement through the Dependent Day Care Reimbursement Account and vice versa. Furthermore, any expenses for which you are reimbursed through your Dependent Day Care Reimbursement Account reduce the "qualified expenses" you can consider when computing the dependent day care tax credit. This rule greatly reduces the possibility of being able to use both the Dependent Day Care Reimbursement Account and the dependent day care tax credit. In general, the greater your income, the more advantageous it is for you to use the Dependent Day Care Reimbursement Account.

Whether you claim the dependent day care tax credit or utilize the Dependent Day Care Reimbursement Account, you will have to complete Form 2441 for dependent day care expenses (or the equivalent Schedule 2 if you file Form 1040A) and attach it to your tax return. Among other things, this form requires information about the person(s) or organization who provided the dependent day care and requires a computation of the amount excludable from your taxable income.

Specific questions regarding the tax advantages of participating in the Health Care Reimbursement Account or the Dependent Day Care Reimbursement Account should be directed to your personal tax advisor.

Effect on Social Security

Because your before-tax reimbursement account deposits reduce your taxable salary, your Social Security taxes will be lower if you earn less than the Social Security wage base. As a result, any Social Security benefits you receive at retirement or during a disability may be reduced slightly if you have participated in one or both of the reimbursement accounts. If you earn more than the Social Security wage base, your Medicare tax will be reduced by 1.45% of your "before-tax" reimbursement account deposits.

Effect on other benefits

Your before-tax reimbursement account deposits will not affect other EY US benefits, such as pension, life insurance, disability and 401(k) contributions.

Eligible expenses

Health Care Reimbursement Account

Expenses eligible for reimbursement through the Health Care Reimbursement Account include health care expenses incurred by you, your spouse* and your dependents, as long as the expenses:

- Are incurred only during the period of participation in which you made your Health Care Reimbursement Account deposits
- Are not reimbursed under any plan maintained by EY US or a plan maintained by any other source (such as your spouse's group health plan or Health Care Reimbursement Account)

"Eligible health care expenses" include most health care expenses the IRS would allow you to deduct on your federal income tax return. Examples include:

- Medical and dental deductibles, coinsurance and copayment amounts, and expenses in excess of reasonable and customary charges not covered by your group medical and dental plans or the plans of your spouse which you are required to pay
- Vision care expenses, such as eye exams, treatment, eyeglasses and contact lenses
- Hearing care expenses, such as examinations and hearing aids
- Certain over-the-counter (OTC) drugs related to medical care are eligible for reimbursement as long as the claim is accompanied by a doctor's prescription, as regulated by state law or a receipt indicating the prescription number in addition to the date purchased, purchaser and amount. Please refer to "Check Eligible Expenses" on the Reimbursement Accounts section of the Better You website for further information.
- Prescription drug copayments and the cost difference between generic drug and brand-name drug when drug is purchased in lieu of a generic.

Consult your personal tax advisor for an additional list of eligible health care expenses. Although you may be able to deduct long-term care expenses on your federal income tax return, you may not use your Health Care Reimbursement Account to cover long-term care expenses.

Expenses incurred for health club dues, cosmetic surgery or treatment, or marriage and family counseling are not eligible.

In addition, health care premiums paid by either you or your spouse for coverage under an employer- or government-sponsored plan or for private health care coverage are not eligible for reimbursement.

Dependent Day Care Reimbursement Account

Expenses eligible for reimbursement through the Dependent Day Care Reimbursement Account include day care expenses for your children, parents or other dependents,[1] as long as the expenses:

- Are incurred during the period of participation and through the end of the calendar year in which you made your Dependent Day Care Reimbursement Account deposit amounts
- Are not reimbursed under any plan maintained by any other source (such as your spouse's Dependent Day Care Reimbursement Account)
- Are necessary for you to work. If you are married, both you and your spouse must be working or your spouse must be a full-time student or be incapable of caring for himself or herself. A full-time student is one who is enrolled in a school for the number of hours or classes that the school considers full-time. The student must be enrolled at least five calendar months during the calendar year of your participation. A spouse who is incapable of self-care must live in the same home as the employee for more than half of the year.

[1] Expenses incurred by domestic partners are not eligible for reimbursement unless your domestic partner is a dependent and you have filed the certification of Legal Tax Dependent Form (IRS#152) with the Better You Benefits Center.

"Eligible expenses" include any dependent day care expenses the IRS would allow you to count for the dependent day care tax credit on your federal income tax return. If you are divorced and have custody of your child, the child's day care expenses may qualify even if you do not claim the child as a dependent on your income tax return.

Following are examples of eligible dependent day care expenses:

- An individual caring for your child(ren) under age 13, while you and your spouse work or your spouse is attending school full-time
- Outside day care for a dependent who is mentally or physically unable to care for himself or herself, regardless of age, and who lives with you for more than half of the year, spends at least eight (8) hours each day in your home and depends on you for more than one-half of his or her support. Custodial care charges are not eligible expenses.
- A day care center that provides care for more than six individuals and is paid for the services provided. The center must meet all applicable state and local laws.
- A nursery school, preschool or summer program for your child(ren) — including lunches. However, overnight camp charges and kindergarten expenses are not eligible expenses.
- Social Security, federal and state unemployment taxes, workers' compensation, and state disability premiums you pay as the employer of an individual providing dependent day care services

Amounts paid to a spouse, a family member under age 19, or to an individual you claim as a dependent on your federal income tax return are not eligible for reimbursement through the account.

YSA issues periodic statements of the dependent day care expenses paid for you. In addition, the firm will report to the IRS any information concerning your Dependent Day Care Reimbursement Account that is required.

Please note, it is your responsibility to obtain Social Security numbers or other applicable tax ID numbers of all dependent day care providers that you will need when filing your tax return to claim an exclusion from your taxable income for amounts reimbursed by your Dependent Day Care Reimbursement Account.

The Health Care Reimbursement Account allows for certain over-the-counter (OTC) drugs, medicines and items to be considered eligible for reimbursement under the plan. The only acceptable form of documentation for reimbursement for OTC drugs and medicines is a doctor's prescription, as regulated by state law or a receipt indicating the prescription number in addition to date purchased, purchaser and amount. Please refer to "Check Eligible Expenses" on the Reimbursement Accounts section of the Better You website for information on eligible expenses.

Eligibility, effective date and general information

Eligibility

As a regular full-time or eligible part-time staff member, you are eligible to participate in the Health Care Reimbursement Account or a Limited Use Health Care Reimbursement Account and/or the Dependent Day Care Reimbursement Account. Regular full-time is defined as hired indefinitely or for a stated period of time greater than 3 months and anticipated to work an average of at least 30 hours per week over the next 12-month period. Eligible part-time is defined as hired indefinitely or for a stated period of time greater than 3 months and anticipated to work an average of at least 20 hours per week over the next 12-month period. Partners, principals, interns, temporary staff members, persons classified by the firm as independent contractors and any other persons who perform services for the firm but are paid by an unrelated company are not eligible to participate in the Plan.

Effective date

The effective date of your participation in the EY Reimbursement Accounts can vary, depending on when you enroll.

- If you enroll in one or both of the reimbursement accounts within 31 days of your date of employment or eligibility, your participation will become effective on the first day of the month following your employment date, if you are actively at work. If you are not actively at work, participation becomes effective immediately following your return.
- If you are transferring from a non-US EY member firm to EY US with no break in service, your coverage will begin on the first day of employment with the US firm, provided you have satisfied the eligibility requirements and enrolled within 31 days of eligibility. You must notify your People Consultant of any prior service with a non-US EY member firm.
- If you enroll or change your deposit amounts to one or both of your reimbursement accounts during any subsequent Annual Enrollment period, your participation or change in deposit amounts will become effective on 1 January of the next calendar year.
- If you do not participate in one or both of the reimbursement accounts, you must wait until the next Annual Enrollment period to enroll or until you experience a qualified change in family/employment status.

If you participate in the Health Care Reimbursement Account or the Limited Use Health Care Reimbursement Account and you experience a family/employment status change, you may stop or change your deposit amounts for the calendar year if the requested change is consistent with the event. If you are not participating in the Health Care Reimbursement Account and you experience a family/employment status change, you may start your deposit amounts for the calendar year if the requested change is consistent with the event to achieve compliance with IRS rules and regulations. You must contact the Better You Benefits Center by accessing **http://digital.alight.com/ey** on the Internet or by calling +1 877 339 1239 within 31 days of the event to make a change.

If you participate in the Dependent Day Care Reimbursement Account and you experience a family/employment status change, you may stop or change your deposit amounts for the calendar year, if the requested change is consistent with the event. If you are not participating in the Dependent Day Care Reimbursement Account and you experience a family/employment status change, you may start your deposit amounts for the calendar year, if the requested change is consistent with the event to achieve compliance with IRS rules and regulations. You must contact the Better You Benefits Center by accessing **http://digital.alight.com/ey** on the Internet or by calling +1 877 339 1239 within 31 days of the event to make a change.

A family/employment status change is defined by IRS regulations and can include:

- Marriage or divorce
- Birth or adoption of a child
- Loss of a dependent
- Change in employment status
- Change in family member's employment status

- Change in family member's medical or dental coverage (including significant increase in premium) or termination of their employer's contributions
- Dependent child no longer eligible
- Change in zip code
- Significant increase in day care cost
- Change in day care provider
- Spouse's plan has later Annual Enrollment period

Changes must be consistent with the event.

The change in your deposit amount will be made the first pay cycle following the date your elections are received as long as the change is made within 31 days of the event. Changes will not be retroactive.

If you do not contact the Better You Benefits Center to report your family/employment status change within 31 days of the event, you must wait until a subsequent Annual Enrollment period to change your Reimbursement Account deposit amount(s). The change will not be retroactive. Your participation or change in deposit amount(s) will become effective on 1 January of the next calendar year.

Participation

Participation in Reimbursement Accounts is voluntary. You participate by making your election within 31 days of your date of employment or during any subsequent Annual Enrollment period.

If you do not enroll within 31 days of your date of employment or eligibility, zero Reimbursement Accounts deposit amounts will automatically be elected for you.

Certain situations can affect your participation in the accounts. These situations are outlined below.

- If you resign, terminate employment, are on long-term disability, retire or die, your reimbursement accounts deposit amounts stop.
- If you take a paid leave of absence or are on short-term disability with pay, deposits to your reimbursement account will continue as long as you continue to be paid. However, if you are on disability and your salary continuation ceases, or you take an unpaid leave of absence, your deposits may be continued on an after-tax basis. You will receive a Leave of Absence benefits packet from the Better You Benefits Center upon commencement of your leave.
- If you become ineligible or are promoted to partner/principal, your deposits will end as of the date you become ineligible or are promoted to partner/principal.

Annual Enrollment

Re-enrollment is required during each subsequent Annual Enrollment period to continue your participation in your Health Care and/or Dependent Day Care Reimbursement Accounts.

If you do not re-enroll during any subsequent Annual Enrollment period, your Health Care Reimbursement Account or Limited Use Health Care Reimbursement Account and/or Dependent Day Care Reimbursement Account deposit amounts will stop automatically, effective 1 January of the next year.

Making deposit amounts

To fund your Reimbursement Accounts, deposits are deducted from your pay before federal income and Social Security taxes are withheld, thus reducing your taxable income and your taxes.

You may deposit up to $2,650 each year to the Health Care Reimbursement Account. You may deposit up to $5,000 (subject to IRS limitations) each year to the Dependent Day Care Reimbursement Account ($2,500 each year, if you and your spouse file separate income tax returns). Due to IRS regulations, the maximum annual amount that you can deposit into the Dependent Day Care Reimbursement Account may be reduced. You will be notified each plan year if these limitations apply to you. To determine your semimonthly deposit amounts, decide on your annual health care and/or dependent day care deposit amounts and divide these amounts by the number of semimonthly pay periods you will participate in the accounts during the year (24 for a full year).

Your annual Dependent Day Care Reimbursement Account deposit amounts can be no more than your earnings or your spouse's earnings, whichever amount is less. Your spouse — if a full-time student or incapable of caring for himself or herself — is deemed to have earnings of $250 per month ($500 if there are two or more dependents) for each month such status or condition continues.

The before-tax deposit amounts are deducted from your salary and credited to your Reimbursement Accounts.

Your initial deposit amounts will be made the first pay cycle following the date your elections are received. Your effective date of participation is the month after your date of employment or eligibility or the date of your family/employment status change as long as you enroll within 31 days of the above.

If you enroll or change your deposit amounts to your reimbursement accounts during any subsequent Annual Enrollment period, your participation or change will become effective on 1 January of the next calendar year.

Termination of participation

Participation under the reimbursement accounts will cease at the end of the month in which one of the following occurs:

- You leave the firm
- You do not make the required contributions by the required due date
- You stop your reimbursement account deposits as a result of a change in family status
- The Plan terminates or is amended to exclude the class of individuals in which you are included

If you become ineligible or are promoted to partner/principal, your deposits will end as of the date you become ineligible or are promoted to partner/principal.

Continuation of participation

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers, such as EY US, sponsoring reimbursement accounts to offer participating staff members the opportunity for a temporary extension (called COBRA continuation coverage) in certain instances where participation under the Plan would otherwise end.

If you leave the firm and were enrolled in the Health Care Reimbursement Account, you may continue participation by making contributions on an "after-tax" basis. You may elect to continue your coverage at the level previously elected. You will be allowed to continue your Health Care Reimbursement Account participation and receive reimbursement for health care expenses incurred through the end of the calendar year in which your employment ceased. If COBRA continuation coverage is elected, you must pay the full monthly contribution (after-tax) plus a 2% percent administrative fee.

If you have any questions, access Better You at **http://digital.alight.com/ey** or call +1 877 339 1239.

General provisions

Amendment and interpretation

The firm (or its delegate) has the sole and absolute discretion to construe and interpret the provisions of the Plan, to make findings of fact, determine the rights and status of participants and others under the Plan and decide disputes under the Plan, other than disputes involving claims for benefits under the Reimbursement Accounts. The firm has delegated to the claims processor the sole authority to make determinations on claims for benefits and on appeals of denied claims. In making such determinations, the claims processor shall have the discretion to construe and interpret the Plan, to make findings of fact and determine the rights and status of participants and others under the Plan. To the extent permitted by law, such interpretations, findings, determinations and decisions shall be final and conclusive as to all persons for all purposes of the Plan. Benefits under the Plan shall be paid only if the firm (or its delegate) determines, in its discretion, that the person claiming benefits is entitled to them. While the firm intends to continue the benefits described herein, it reserves the right to amend or terminate the Plan or the benefits described herein in any manner and at any time without prior notice.

Filing a claim and receiving reimbursements

Claim processor

The claim processor for the EY Reimbursement Accounts is Your Spending Account (YSA), part of Better You.

How to file a claim

During the year, as you and your family members incur eligible expenses, you may file a Reimbursement Accounts claim.

All unreimbursed, eligible medical, dental, eyewear or pharmacy claims submitted to EY US plans administered by Anthem BlueCross BlueShield (with AmeriBen as claims processor), UnitedHealthcare, CVS/Caremark, MetLife, EyeMed or YSA will be automatically forwarded to your Health Care Reimbursement Account for processing. If you are enrolled in a Limited Use Health Care Account, only MetLife (dental) and EyeMed claims will be automatically reimbursed.

Any claim not automatically forwarded to your Health Care Reimbursement Account should be submitted to YSA. Claims may be submitted via the YSA website or the YSA mobile app as described on the Reimbursement Accounts section of the Better You website.

Any claim for health care expenses must be accompanied by a receipt indicating the date of service. A canceled check will not be accepted as a receipt.

Claims for dependent day care reimbursement must be accompanied by an itemized statement from the dependent care center provider or in-home provider indicating dates of service, amount charged, and name and age of dependent. If dependent care services are provided by a relative, a paid receipt or canceled check is adequate documentation. **You must provide the Social Security number, employer identification number or other applicable tax ID number of the day care provider on the claim form.**

To be eligible for health care reimbursement, claims incurred in the same calendar year in which you make deposit amounts will be paid as they are submitted, provided they do not exceed your elected annual deposit amount. If participation starts after the beginning of the calendar year or if participation terminates, only eligible expenses incurred during your **period of participation will be paid.**

To be eligible for dependent day care reimbursement, claims must be incurred on or after your participation begins (see the section entitled "Effective date" on page 10 for specifics on when participation begins) and in the same calendar year you make deposit amounts.

Expenses incurred in one calendar year cannot be paid from deposit amounts made in another calendar year. Therefore, the date you actually pay for the service rendered has no impact on eligibility.

You have until 31 March to file a claim for expenses incurred during the prior calendar year. After that date, any claim for expenses incurred in the prior year cannot be paid.

Each time you receive a check from YSA, it will be accompanied by an explanation describing the eligible expenses reimbursed.

If you have questions about how to file a reimbursement accounts claim or if you have questions about the timing or payment of a claim filed, contact YSA at +1 877 339 1239.

If you participate in one or both reimbursement accounts, you will receive periodic statements from YSA.

Receiving reimbursements

Reimbursements for eligible health care expenses and eligible dependent day care expenses are processed differently, as discussed below.

Health care. You will receive reimbursement of eligible health care expenses from YSA periodically.

If you have filed a health care claim for expenses greater than actual deposit amounts, you will be reimbursed up to your total elected deposit amounts.

Dependent day care. You will receive reimbursement of eligible dependent day care expenses from YSA periodically provided you have sufficient deposits in your account to pay all or a portion of your submitted dependent day care expenses.

Recovery of overpayment

In the event of an erroneous payment or payment amount in excess of the Plan's obligation, the Plan may reduce future benefits by the amount of the error or may recover the excess directly from the person to or for whom the payment was made. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other manner.

Filing deadline

YSA must receive your claim for eligible expenses by 31 March of the following year.

If a claim is denied — claims and appeals procedures

(A) Initial benefit determination

If you believe you are entitled to receive a benefit under this Plan, you should follow the procedures outlined above on how to file a claim.

EY US has delegated to the claims processors the sole authority to make determinations on claims for benefits and on all appeals of denied claims.

For purposes of these claims procedures, "you" means any participant seeking a benefit under the Plan or an authorized representative of a participant.

Notification of initial adverse benefit determination

Unless a claim for reimbursement of dependent care expenses is allowed in total, the claim processor will notify you of the total or partial denial of your claim within 90 days after the claim is filed by you (plus an additional period of 90 days if special circumstances so require, provided that notice of the extension of time is given to you before the expiration of the initial 90-day period).

Unless a claim for reimbursement of health care expenses is allowed in total, the claim processor will notify you of the total or partial denial of your claim within 30 days after receipt of a claim (plus an additional 15 days if necessary due to circumstances beyond the control of the Plan, provided that the claim processor provides you with notice of the time extension and a statement of the circumstances requiring the time extension and the date by which the claim processor expects to render a benefit determination). If the time extension is needed because you failed to provide all of the information necessary to make a determination, the notice of extension will specifically describe the missing information and allow you 45 days from the date the notice is received by you to provide the missing information.

All notices to you of adverse benefit determinations of dependent care expenses will be in writing (or in electronic format) and include:

1. The specific reason or reasons for the adverse determination
2. Reference to the specific Plan provisions on which the determination is based
3. A description of additional material or information needed to complete the claim and explanation of why the information is needed
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review

If the notice to you involves a claim relating to reimbursement of health care expenses, the notice will also include:

1. The specific internal rule, guideline, protocol or similar criterion, if any, that was relied upon in making the adverse determination or a statement thereof with a statement that a copy of the same is available to you free of charge upon request
2. If a denied claim is based on medical necessity, experimental treatment or similar limit, a statement explaining the scientific or clinical judgment of the determination and applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you

(B) Appeal of a denied claim

Within 180 days of receipt of the notice of the denial of your claim, you can appeal the denial by filing with the claim processor written request for a review of your claim.

Upon receiving a written appeal from you, the claim processor will:

1. Provide you with the opportunity to submit written comments, documents, records and other information relating to the claim
2. Upon request, provide reasonable access to, and copies of, all documents and other information relevant to your claim for benefits at no charge to you

Upon receiving a written appeal from you regarding the denial of health care expenses, the claim processor will, in addition to complying with the above:

1. Designate a named fiduciary to conduct a full and fair review of your claim who is not the individual, nor the subordinate of the individual, who made the original adverse determination and who may not give deference to the initial adverse determination
2. Confirm that the named fiduciary considers all of the comments, documents, records and other information submitted by you without regard to whether the information was submitted or considered in the initial benefit determination
3. Upon request, provide you with the name of any medical or vocational experts with whom the claim processor consulted in making its original determination

If the adverse determination was based, in whole or in part, on a medical judgment, the named fiduciary reviewing the claim on appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. However, the medical professional will not be an individual, nor a subordinate of an individual, who was consulted in the initial benefit determination of the claim.

Notification of determination on review

Generally, the claim processor will notify you of the determination on review within a reasonable time but not later than 60 days after receiving your request for review. However, in the case of a request for review of a claim for health care expenses that is filed with YSA, you will be notified of the determination on review not later than 30 days after receipt of your request for review.

For an appeal of claims involving dependent care expenses, if, due to special circumstances, the claim processor cannot make a determination within 60 days after receipt of the request for review, the claim processor may have up to an additional 60 days to make a determination on review. The claim processor will provide to you a notification of the time extension that will include:

1. An explanation of the circumstances requiring the extension
2. The date by which the claim processor expects to render a decision

The time extension notice will be provided to you before the initial 60-day period expires.

If the determination on appeal for dependent care expenses is adverse to you, the notice of determination on review will contain:

1. The reasons for its denial
2. Reference to the specific Plan provisions on which the benefit determination is based
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claim
4. A statement describing your right to file a civil action under Section 502(a) of ERISA

In addition to the content requirements listed above, if the notice to you involves a claim relating to reimbursement of health care expenses, the notice will also include:

1. The specific internal rule, guideline, protocol or similar criterion, if any, that was relied upon in making the adverse determination or a statement thereof with a statement that a copy of the same is available to you free of charge upon request
2. If a denied claim is based on medical necessity, experimental treatment or similar limit, a statement explaining the scientific or clinical judgment of the determination and applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you

3. In the case of a request for review that was filed with YSA, a description of the second-level review procedures and the time limits applicable to those procedures

(C) Second appeal of a denied claim for health care expense reimbursement

If you are not satisfied with the first-level appeal decision with respect to a claim for reimbursement of health care expenses, you have the right to request a second-level appeal. Your second-level appeal request must be submitted within 60 days from receipt of the first-level appeal decision.

Your request for a second-level appeal should include the same information as your level one appeal (see "Appeal of a Denied Claim" above). The second-level appeal will be conducted by a named fiduciary designated by the claim processor in the same manner as the first-level appeal.

The claim processor will notify you within a reasonable period of time, but not later than 30 days after receipt of the request for review of the first-level appeal decision.

Notification to you of an adverse benefit determination on review of a second-level appeal will be provided in the same manner and contain the same information as that described above in the section entitled notification of adverse benefit determination on review.

No legal action may be brought to recover Plan benefits or to seek redress related to the Plan until all claim review and appeal procedures provided by the Plan have been exhausted. All legal actions with respect to Plan benefits must be brought within 12 months after the date of notification of a final adverse determination that is made after the exhaustion of all such claim review and appeal procedures.

The Employee Retirement Income Security Act of 1974 (ERISA)

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA):

Plan name(s)	EY Flexible Benefits Program EY Dependent Day Care Plan
Employer identification number	34-6565596
Plan number(s)	515 516
Plan sponsor	Ernst & Young US LLP 200 Plaza Dr. Secaucus, NJ 07094
Type of plan(s)	Welfare: Cafeteria Plan[2] Welfare: Dependent Care Benefits[2]
Plan year	1 January to 31 December
Plan administrator	Ernst & Young US LLP 200 Plaza Dr. Secaucus, NJ 07094 Telephone: +1 201 872 2200
Plan costs	Paid by the Employee and Ernst & Young US LLP
Agent for service of legal process	General Counsel of Ernst & Young US LLP 5 Times Square New York, NY 10036 Telephone: +1 212 773 2500
Plan eligibility	Refer to this booklet for description and eligibility requirements.
Claim processor	Your Spending Account P.O. Box 64030 The Woodlands, TX 77387-4030
How to file a claim	Refer to this booklet for information on filing a claim.

Your rights under ERISA

The following statement is required by federal law and regulation:

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

- Receive information about your plan and benefits
- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, 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

[2] The Reimbursement Accounts are benefits offered under the Ernst & Young Flexible Benefits Program, which is a cafeteria plan under Section 125 of the Internal Revenue Code.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 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. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date of your coverage.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people, who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If you have any questions about your plan, you should contact the Plan administrator. If you have 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, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US 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.

Exhibit 1 — Notice of Privacy Practices

This notice describes how medical plan information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

This Notice of Privacy Practices (Notice) describes how your health information may be used or disclosed to carry out payment or health care operations and for other purposes that are permitted or required by applicable law. This Notice also describes your rights to access and control your health information.

"Health information" is your individually identifiable health information, including demographic and genetic information, that relates to (i) your past, present or future physical or mental health or condition, (ii) your healthcare treatments, or (iii) payments for your treatment.

Ernst & Young US LLP (EY or the firm) offers its partners/principals and staff members a number of benefits, including medical, dental, assistance program and others. This Notice applies to partners/principals and staff members who participate in the following plans, referred to below as "Group Health Plans":

- EY Medical Plan
- EY Dental Program
- EY/Assist
- Eyewear Plan
- EY Health Care Reimbursement Account
- Medical Evacuation Plan
- Medical Examination Plan

Note that partners/principals and staff members who select long-term care coverage or choose to receive benefits insured through a health maintenance organization (HMO) will receive a Notice of Privacy Practices related to those benefits directly from those insurers.

EY has restricted its access to your health information in order to protect your privacy. Generally, EY does not receive any specific health information about you. Rather, it is the third party administrators of the Group Health Plans that are most likely to have your health information and use or disclose it as described in this Notice. Therefore, in most cases initial requests regarding your health information rights, as described in this notice, will be directed to the appropriate third-party administrator. You may also contact EY or its Health Plans Privacy Official directly regarding those rights, as well as any complaints or additional inquiries that you may have.

How the Group Health Plans may use or disclose your health information

Your health information is protected from inappropriate use or disclosure. All individuals who review your health information are required to comply with requirements that protect the confidentiality of your health information. Your health information may be reviewed only when there is an appropriate reason to do so and only the minimum amount of information necessary may be used or disclosed.

The main reasons for which your health information may be used and disclosed are for purposes of payment and health care operations under the Group Health Plans. The following paragraphs describe these and other uses and disclosures, together with some examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made.

For payment

The Group Health Plans may use and disclose your health information to others for purposes of facilitating payment for treatment and services that you receive. For example, the Group Health Plans may provide information to a health care provider or a third-party payor, such as an administrator or insurance company, regarding amounts that are covered under the Group Health Plans. Additionally, your health information may be disclosed to the administrators of the Group Health Plans for various payment-related

functions, such as eligibility determination, audit and review, response to inquiries or disputes, determination of medical necessity and utilization review. The information may identify you, your diagnosis and treatment or supplies used in the course of treatment.

For Healthcare operations

Your health information may be used and disclosed for a Group Health Plan's operations. These purposes include evaluating Group Health Plan products or services, administering those products or services and processing transactions. For example, your health information may be disclosed to EY personnel of the Group Health Plans, or third parties retained or hired by the Group Health Plans for quality improvement, business planning and cost management purposes.

Your health information may also be disclosed to business associates who are assisting the Group Health Plans if they need to receive health information to provide a service. Business associates must also abide by the privacy rules relating to the protection of your health information. Examples of business associates are billing companies, data processing companies or companies that provide general administrative services. Protected health information may be disclosed to reinsurers for underwriting, audit or claim review reasons. The Group Health Plan is prohibited from using or disclosing protected health information that is genetic information for underwriting purposes. Your health information may also be disclosed in connection with a merger, acquisition or divestiture involving the firm's business in order to achieve a smooth transition of your Group Health Plan benefits.

For treatment

The Group Health Plans do not provide medical treatment directly, but may disclose your health information to a health care provider who is giving treatment. For example, a Group Health Plan may disclose the types of prescription drugs you currently take to an emergency room physician, if you are unable to provide your medical history due to an accident.

Plan sponsor

The Group Health Plans or health insurance issuer or HMO, acting on behalf of the Group Health Plans, may disclose health information to EY, the sponsor of the Group Health Plans. However, at no time will the Group Health Plans disclose information to EY for employment-related actions or decisions.

Required by law

The Group Health Plans may use and disclose health information about you when required by federal, state or local law. For example, the Group Health Plans may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority, including in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process
- To report information related to victims of abuse, neglect or domestic violence
- To assist law enforcement officials in their law enforcement duties

Public health

Your health information may be used or disclosed for public health activities, such as assisting public health authorities or other legal authorities to prevent or control communicable disease, injury, or disability or for other health oversight activities.

Decedents

Your health information may be disclosed to funeral directors, medical examiners or coroners when required by law, to enable them to carry out their lawful duties, including identifying a deceased individual or to determine the cause of death.

Organ/tissue donation

Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Health and safety

Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Your health information may be disclosed to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow those agencies to carry out their responsibilities in specific disaster situations.

Government functions

Your health information may be disclosed for specialized government functions, such as protection of public officials or reporting to various branches of the armed services.

Health information about you may also be disclosed to federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Workers' compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation.

Health-related benefits or services

Your protected health information will not be disclosed to any other company for their marketing use. However, your health information may be used or disclosed to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about treatment alternatives or other health-related benefits and services that may be of interest to you. This information may identify you, your diagnosis and treatment or supplies used in the course of treatment.

When requested as part of a regulatory or legal proceeding

If you or your estate is involved in a lawsuit or a dispute, protected health information may be disclosed about you in response to a court or administrative order. Health information may be disclosed about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the health information requested. Health information about you may be disclosed to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

Other uses

Other uses and disclosures of health information not covered by this notice and permitted by the laws that apply to the Group Health Plans will be made only with your written authorization or that of your legal representative. If the Group Health Plans are authorized to use or disclose health information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that action has been taken relying on the authorization or if the authorization was obtained as a condition of obtaining your insurance coverage. You should understand that such disclosed information will not be able to be taken back regarding any disclosures already made with your prior authorization.

Your health information rights

You have the right to:

- Request a restriction on certain uses and disclosures of your health information, or request that your health information not be disclosed to someone who may be involved in your care or payment for your care, like a family member or friend. While your request will be considered, the Group Health Plans are not required to agree to it. If a particular Group Health Plan does agree to it, it will comply with your request. To request a restriction, you must make your request in writing to Michael J. Spicci, Health Plans Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094. In your request, you must indicate (1) what information you want to limit; (2) whether you want to limit the Group Health Plan's use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). The Group Health Plan will not agree to restrictions on health information uses or disclosures that are legally required, or which are necessary to conduct EY's or the Group Health Plans' business.
- Obtain a paper copy of this notice upon request, even if you have previously agreed to receive the notice electronically.
- Inspect and obtain a copy of your health information record. If your protected health information includes an electronic health record (i.e., an electronic record of health-related information created by your health care provider), beginning 17 February 2010, you have the right to inspect or obtain an electronic copy of your electronic health record. To inspect and copy health information, you must submit your request in writing to Michael J. Spicci, Health Plans Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094. To receive a copy of your health information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of health information will not be made available for inspection and copying. This includes health information collected in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances your request to inspect and obtain a copy of your health information may be denied. In that case, you may request that the denial be reviewed. The review will be conducted by an individual chosen by the

Group Health Plan who was not involved in the original decision to deny your request. The Group Health Plan will comply with the outcome of that review.

- Request that your health information be amended while it is kept by or for the Group Health Plans. You must provide your request and your reason for the request in writing, and submit it to Michael J. Spicci, Health Plans Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094. Your request may be denied if it is not in writing or does not include a reason that supports the request. In addition, your request may be denied if you ask for an amendment of health information that:
  - Is accurate and complete
  - Was not created by the Group Health Plans, unless the person or entity that created the health information is no longer available to make the amendment
  - Is not part of the health information kept by or for the Group Health Plan
  - Is not part of the health information that you would be permitted to inspect and copy
- Request communications of your health information by alternative means or at alternative locations. For example, you can ask that the Group Health Plans only contact you at work or in writing. To request confidential communications, you must make your request in writing to Michael J. Spicci, Health Plans Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094 and specify how or where you wish to be contacted. All reasonable requests will be accommodated.
- Request a list of the disclosures made of health information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel, made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to Michael J. Spicci, Health Plan Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094. Your request must state the time period for which you want to receive a list of disclosures. The time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be provided free of charge. You may be charged for additional requests. You will be notified of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Personal representatives

You may exercise your health information rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health information or allowed to take any action for you.

The Group Health Plans retain discretion to deny access to your health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Group Health Plans or with the Secretary of the Department of Health and Human Services. To file a complaint with the Group Health Plans, please contact Michael J. Spicci, Health Plans Privacy Official, EY, 200 Plaza Dr., Secaucus, NJ 07094. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions regarding how to file a complaint, please contact the Group Health Plans at +1 201 872 2870 or by e-mail at mike.spicci@ey.com.

Obligations of the Group Health Plans

The Group Health Plans are required to:

- Maintain the privacy of your health information
- Provide you with this notice of legal duties and privacy practices with respect to your health information
- Abide by the terms of this notice
- Notify you if the Group Health Plans are unable to agree to a requested restriction on how your information is used or disclosed
- Accommodate reasonable requests that you may make to communicate health information by alternative means or at alternative locations

Changes to the plan's policies and procedures

The Group Health Plans reserve the right to change their health information practices, as set forth in their privacy policies and procedures and to make the new provisions effective for all protected health information they maintain. The Plans will provide a notice whenever there is a material change to the privacy policies and procedures or its permitted uses and disclosures. State law may provide for additional protection of your health information. Please contact the person identified below for more information.

Changes to this notice

The Group Health Plans are required to abide by the terms of this Notice currently in effect; however, the Group Health Plans reserve the right to change the terms of this Notice at any time. The Group Health Plans reserve the right to make the revised or changed Notice effective for health information it already has about you as well as any health information that is received in the future. You will receive a copy of any revised Notice by mail or by e-mail.

Privacy official

The Group Health Plans have a designated Privacy Official who may be contacted for further information:

Michael J. Spicci
Health Plans Privacy Official
Ernst & Young US LLP
200 Plaza Dr.
Secaucus, NJ 07094
+1 201 872 2870

No guarantee of employment

Nothing contained in this Notice shall be construed as a contract of employment between EY and any employee, nor as a right of any employee to be continued in the employment of EY, nor as a limitation of the right of EY to discharge any of its employees, with or without cause.

No change to plans

Except for the privacy rights described in this Notice, nothing contained in this notice shall be construed to change any rights or obligations you may have under the Group Health Plans. You should refer to the Group Health Plan documents for complete information regarding any rights or obligations you may have under the Group Health Plans.

Effective date

This notice is effective 1 January 2020.

Exhibit 2 — The EY Health Plans HIPAA Privacy

Security Amendment Section A-1 general

A-1-1 **Limited applicability**. This Exhibit 2 is for the sole and limited purpose of complying with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 164.102 et seq., as amended from time to time, and any successor thereto (the Privacy Rule) and Security Standards for the Protection of Electronic Protected Health Information contained in 45 CFR § 164.302 et seq. (the Security Rule), each promulgated under Title II of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) relating to the permitted disclosure of Protected Health Information by the Plan, or by an HMO or Health Insurance Issuer with respect to the Plan, to the Plan Sponsor and to the security of Electronic Protected Health Information that is created, received, maintained or transmitted on behalf of the Plan. This Exhibit 2 shall not affect, or be taken into account in determining, the benefits under the Plan with respect to any individual. To the extent that any of these provisions are no longer required, they shall be deemed deleted and shall have no further force or effect.

A-1-2 **Interpretation**. This Exhibit 2 is intended to comply with the Privacy Rule and shall be construed in a manner that will effectuate this purpose. This Exhibit 2 shall not be construed in a manner that is inconsistent with its stated purpose.

A-1-3 **Effective date**. The effective date of this Exhibit 2 is 14 April 2003.

Section A-2 definitions

A-2-1 **General.** For purposes of this Exhibit 2, the following terms shall have the meanings given to them below. To the extent not defined for purposes of this Exhibit 2, capitalized terms shall have the meanings given to them in the Plan.

"**Electronic protected health information**" means Protected Health Information that is transmitted by electronic media or is maintained in electronic media.

"**Firm**" means Ernst & Young US LLP or any successor thereto.

"**Health insurance issuer**" means a health insurance issuer as defined in 45 CFR § 160.103 or any successor thereto.

"**Health plan privacy official**" means the health plan privacy official as defined in Section A-4-1 hereof.

"**HMO**" means a health maintenance organization and dental maintenance organization as defined in 45 CFR § 160.103 or any successor thereto.

"**Participation and enrollment information**" means that information described in 45 CFR § 164.504(f)(1)(iii) or any successor thereto.

"**Plan**" means the EY Health Plans (Medical Plan, Medical Plan for Certain Medicare-Eligible Retirees, Eyewear, Dental Program and Health Care Reimbursement Accounts) as amended from time to time.

"**Plan administration functions**" means administration functions performed by the Plan Sponsor on behalf of the Plan, but excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

"**Plan Sponsor**" means the plan sponsor as defined in Section A-3-1 hereof.

"**Policies and procedures**" means those policies and procedures with respect to Protected Health Information established and maintained by the Plan pursuant to the Privacy Rule.

"**Protected health information**" means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media at 45 CFR § 162.103, or transmitted or maintained in any other form or medium; provided, however, that Protected Health Information does not include Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC. § 1232g, records described at 20 USC. § 1232g(a)(4)(B)(iv) and employment records held by a health plan in its role as employer.

"**Required by law**" means required by law as defined in 45 CFR § 164.103.

"**Settlor Functions**" means those functions described in 45 CFR § 164.504(f)(1)(ii)(A) and (B) or any successor thereto.

"**Summary health information**" means summary health information as defined in 45 CFR § 164.504(a) or any successor thereto.

Section A-3 plan sponsor

A-3-1 **Identity of Plan Sponsor.**

a. The Firm shall be the Plan Sponsor for purposes of the Privacy Rule when performing Plan Administration Functions or Settlor Functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rule, and when acting on behalf of the Plan's participants and beneficiaries with respect to Participation and Enrollment Information.

b. The Health Plan Privacy Official shall act on behalf of the Plan Sponsor and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

c. Individuals and classes of individuals identified in Section A-5-2 hereof shall assist the Health Plan Privacy Official.

A-3-2 **Responsibilities and undertakings.**

a. The Plan Sponsor shall be responsible for making any necessary certifications to the Plan. Such certifications shall be delivered to the Health Plan Privacy Official or his or her delegate.

b. The Plan Sponsor also undertakes and agrees that it:

(i) Shall not use or disclose Protected Health Information other than as permitted or required by the Plan or as Required by Law

(ii) Shall require any agents or subcontractors to whom it discloses Protected Health Information to agree to the same restrictions on the use and disclosure of Protected Health Information as apply to the Plan Sponsor with respect to such Protected Health Information

(iii) Shall not use or disclose Protected Health Information for any employment-related actions of the Firm

(iv) Shall not use or disclose Protected Health Information in connection with any other benefits or benefit plan, program or arrangement of the Firm (except to the extent that such other benefits, or benefit plan, program or arrangement is part of an organized health care arrangement of which the Plan also is a part)

(v) Shall report to the Plan any uses or disclosures of Protected Health Information inconsistent with the terms of this Exhibit 2 of which it becomes aware

(vi) Shall make Protected Health Information available in accordance with an individual's right of access as set forth in 45 CFR § 164.524

(vii) Shall make Protected Health Information available for amendment and shall incorporate amendments in accordance with 45 CFR § 164.526

(viii) Shall make information available to provide any required accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528

(ix) Shall make available to the Secretary of the Department of Health and Human Services its internal practices, books, and records relating to the use and disclosure of Protected Health Information from the Plan for purposes of determining the Plan's compliance with Subpart E of 45 CFR § 164

(x) Shall, if feasible, return to the Plan or destroy any Protected Health Information from the Plan that it maintains in any form, and shall retain no copies of the Protected Health Information when the Protected Health Information is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the Protected Health Information, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible.

(xi) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established

Section A-4 Health Plan Privacy Official

A-4-1 **Identity of Health Plan Privacy Official.** The Health Plan Privacy Official shall be the National Director of Benefits of the Firm.

A-4-2 **Power and authority of the Health Plan Privacy Official**. The Health Plan Privacy Official shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

A-4-3 **Responsibilities of the Health Plan Privacy Official**. The Health Plan Privacy Official shall have the duties and responsibilities specified in the Plan's Policies and Procedures. Such duties and responsibilities may also include accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor with respect to disclosures and uses of Protected Health Information, as well as transmitting the certification to any Health Insurance Issuers or HMO's with respect to the Plan, as necessary, in order to permit them to disclose information to the Plan Sponsor based on such certification.

Section A-5 Uses and disclosures of Protected Health Information

A-5-1 **Permitted uses and disclosures of Protected Health Information**

a. **Certification.** The Plan, and any Health Insurance Issuer or HMO with respect to the Plan, may disclose protected health information to the Plan Sponsor only following receipt by the Plan, and any Health Insurance Issuer or HMO of the Plan Sponsor's certification that the Plan has been amended in accordance with the requirements of the Privacy Rule.

b. **Plan administration.** Subject to obtaining written certification from the Plan Sponsor, as described in A-5-1-a. above, the Plan may disclose Protected Health Information to the Plan Sponsor only for the purpose of performing Plan plan Administration Functions. In addition, the Plan, or Health Insurance Issuer or HMO may disclose to the Plan Sponsor Participation and Enrollment Information. The Plan, or Health Insurance Issuer or HMO may also disclose Summary Health Information only for the purpose of:

   (i) Obtaining premium bids from health plans for providing health insurance coverage under or on behalf of the Plan

   or

   (ii) Modifying, amending or terminating the Plan

c. **Compliance with law.** Notwithstanding any provisions of the Plan to the contrary, in no event will the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

A-5-2 **Individuals with access to Protected Health Information**

a. For purposes of the Privacy Rule, the following individuals or groups of individuals under the direct control of the Plan Sponsor will be permitted to have access to Protected Health Information disclosed by the Plan or any Health Insurance Issuer or HMO for the purposes specified.

   (i) Employees and contract or temporary employees of the Total Rewards–Benefits Department

   (ii) In addition, with respect to the Medical Examination Program, the National Director of Partnership Accounting and Administration and staff of Partnership Accounting designated by the National Director of Partnership Accounting and Administration

   (iii) In addition, with respect to the Medical Evacuation Plan, the National Director of Partnership Accounting and Administration, the Director of Mobility Services designated by the National Director or Partnership Accounting and Administration and the staff of the Center for Mobility Services designated by the Director of Mobility Services

b. Any characterization of an individual as being under the direct control of the Plan Sponsor is exclusively for the purpose of the Privacy Rule and has no other significance. Such characterization for purposes of the Privacy Rule does not, for example, create any employment relationship or result in any entitlement to benefits under this Plan or any other benefit plan, scheme or arrangement of the Firm.

c. The Health Plan Privacy Official and his or her delegates, if any, are permitted to have access to Protected Health Information disclosed by the Plan and any Health Insurance Issuer or HMO with respect to the Plan.

A-5-3 **Permitted disclosure with respect to Electronic Protected Health Information**. The Plan may disclose Protected Health Information to the Plan Sponsor only if the Plan Sponsor agrees with respect to any Electronic Protected Health Information that the Plan Sponsor will:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan

b. Establish that the adequate separation as required by the HIPAA Privacy Rule and as set forth in § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures

c. Establish that any agent, including a subcontractor, to whom the Plan Sponsor may provide this information agrees to implement reasonable and appropriate security measures to protect the information

d. Report to the Plan any security incident of which the Plan Sponsor becomes aware

Section A-6 Compliance with established limitations on access, disclosure and use of Protected Health Information

A-6-1 **Noncompliance.** If the Plan Sponsor becomes aware that an employee or other individual listed in Section A-5-2 hereof has failed to comply with the Privacy Rule, the Plan Sponsor shall inform the Health Plan Privacy Official and the Health Plan Privacy Official shall determine in accordance with the Plan's Policies and Procedures, what sanctions, if any, should be imposed. In addition, the Health Plan Privacy Official acting on behalf of the Plan shall notify all individuals required to be notified under the Privacy Rule about such failure and take all necessary action to mitigate any harm caused by an employee's failure to comply with these provisions, as set forth in the Policies and Procedures.

A-6-2 **Compliance with health privacy laws.** To the extent applicable, the Plan will comply with Subpart E of 45 CFR § 164 and any other applicable federal, state and local laws governing the safeguarding of Protected Health Information.

A-6-3 **Interpretation of HIPAA Privacy Rules.** The provisions of this section are meant to comply with (and not expand upon) the requirements of the HIPAA Privacy Rule and shall be interpreted accordingly. In the event that any of the provisions of this section are not applicable, are superseded or are no longer required under HIPAA, they shall be deemed deleted from the Plan and shall have no further force or effect.

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