



# **MARIST COLLEGE FLEXIBLE REIMBURSEMENT PLAN**

## **SUMMARY PLAN DESCRIPTION**

**Effective as of January 1, 2008**

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## SUMMARY PLAN DESCRIPTION

### INTRODUCTION

Marist College (the "Plan Sponsor") is pleased to sponsor an employee benefit program known as the Marist College Flexible Reimbursement Plan (the "Plan") that allows eligible Employees to choose from a menu of different benefits to suit their needs. The available benefits are outlined in this booklet, which serves as the Summary Plan Description.

By participating in the Plan, Employees are able to use tax-free dollars to pay for certain kinds of expenses, which are normally paid for with the Employees' out-of-pocket, taxable dollars. As a result, the Plan provides Employees with the opportunity to pay less tax and have more money to spend and save.

This Summary Plan Description describes the basic features of the Plan and how it operates, including the rules that you must satisfy before you can participate and the laws that protect your rights. This Summary Plan Description does not describe every detail of the Plan. You may request copies of the Plan documents from the Plan Sponsor. **IF THERE IS A CONFLICT BETWEEN THE PLAN DOCUMENTS AND THIS SUMMARY PLAN DESCRIPTION, THE PLAN DOCUMENTS WILL GOVERN.**

It is intended that the Plan shall be an ongoing benefit to Employees. Nonetheless, circumstances may change, and the Plan Sponsor expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason without liability. Amendment or termination of the Plan shall not affect your rights to claims for benefits covered under the Plan prior to such amendment or termination.

Neither a Plan Participant nor the Participant's Spouse or Dependents shall have a contractual right to benefits under the Plan, which interferes with the Plan Sponsor's right to amend the Plan or terminate the Plan. **THE PLAN SPONSOR MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS SHALL NOT VEST.**

Note that the Plan shall not be deemed to be a contract between the Plan Sponsor and its employees or members, or consideration for, or an inducement or condition of, the employment of any person. Nothing contained in this Summary Plan Description shall be interpreted to give any employee the right to remain employed by his or her Employer.

A Glossary, which defines terms used throughout this Summary Plan Document, is attached as Exhibit A for your reference.

### I. PLAN OVERVIEW

The Plan permits eligible Employees to elect to participate in up to two benefit programs (each, a "Benefit"): (A) a Health Flexible Savings Account ("Health FSA"); and (B) a Dependent Care Account Program ("DCAP"). By electing to participate in one or both of these Benefits, the Employee agrees to have a portion of the Employee's upcoming pay contributed to the Plan before it has been subjected to federal income or withholding tax or to Social Security tax. Those contributions are then set aside to be used to reimburse the Employee for certain medical and/or dependent care expenses (as applicable) that are not otherwise reimbursed.

Employees' elections to participate in the Plan are made during the enrollment period prior to the beginning of a Plan Year and must remain in place for the entire Plan Year, with certain special exceptions.

The Plan Sponsor has appointed MVP Select Care, Inc. to be the Plan Administrator. The Plan Administrator is responsible for the management, operation and administration of the Plan.

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

## **II. ELIGIBILITY**

### **A. How can I become a participant in the Plan?**

Those individuals who actually participate in the Plan are called “Participants.” Becoming a Participant is a two-step process. First you must meet specific “eligibility requirements.” Second, once it is determined that you meet these requirements and are “eligible,” you will have to complete certain applications and actually enroll in the Plan as of a specific date.

### **B. What are the “eligibility requirements” for the Plan?**

If you are an Employee (defined below), you are eligible to participate in the Plan as follows:

1. Any regular administrator or faculty employee is eligible on the date of hire; (Adjuncts are not eligible);
2. A CWA employee is eligible after the fourth (4<sup>th</sup>) month of their probationary period;
3. A part-time CWA employee is eligible after six (6) months of service;
4. An exempt secretary is eligible after three (3) months of service;
5. A full-time SEIU employee is eligible after four (4) months of service; a part-time SEIU employee is eligible after six (6) months of service;
6. A full-time security employee is eligible after 180 (one hundred eighty) days; provided that you follow the rules set forth in Section III below.

The following individuals are not eligible to participate in the Plan:

- Any leased employee, or any common-law employee classified by the Plan Sponsor as a contract worker, independent contractor, temporary employee or casual employee even if such an individual is later retroactively reclassified as a common-law employee;
- Any individual who performs services for the Plan Sponsor but who is paid by a temporary or other employment or staffing agency; or
- Any self-employed individual, partner in a partnership, or more-than-2% shareholder in a Subchapter S corporation.

### **C. When will my participation in the Plan end?**

Your participation in the Plan will terminate automatically upon the occurrence of any of the following:

- The Plan terminates;
- Your eligibility to participate ceases;
- You refuse a request for information by the Plan Administrator; or
- Your employment or membership with the Plan Sponsor terminates.

If your employment or membership relationship with the Plan Sponsor is terminated during the Plan Year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan. See Section VI for details regarding certain rights to continued coverage after the termination of employment.

If your coverage terminates because you failed to make required contributions (for example, if you were on an unpaid leave of absence and you did not make required premium payments on an after-tax basis), when you return to service, you will only be permitted to restore your prior elections for the rest of that Plan Year, unless there is another permissible reason to change your election (See Section V.F.).

### **D. How will my Spouse or Dependent’s coverage be affected when my participation ends?**

Your Spouse's or a Dependent's coverage under a Benefit ends when your participation ends, if not earlier:

- For a Spouse, following divorce or a legal separation that terminates coverage under a Benefit; or
- For a Dependent, if the Dependent ceases to satisfy the definition of "Dependent" under the Benefit (for example, the Dependent ceases to be a full-time student or becomes older than the maximum age for coverage).

**E. Can I participate if I return to employment/membership with the Plan Sponsor?**

If your employment or membership with the Plan Sponsor terminates and you later return to employment/membership within 30 days during the same Plan Year, then your prior elections will be reinstated.

If your employment or membership with the Plan Sponsor terminates and you return to employment/membership more than 30 days later, you must satisfy the eligibility requirements again. If you are eligible, you may make new elections.

**III. BENEFITS**

**A. Generally, what Benefits are provided by the Plan?**

The Plan includes the Health FSA and DCAP Benefits, as described in more detail below. Under the Plan, and subject to your eligibility, you can choose to participate in one or both of the Benefits and to pay your Benefit contributions with a portion of your compensation before federal income, withholding or Social Security taxes are withheld.

**Health Flexible Spending Account (Health FSA) Benefits:** Under a Health FSA, an Employee may use pre-tax dollars to pay for qualifying Medical Care Expenses that are not otherwise reimbursed by insurance.

**Dependent Care Assistance Program (DCAP) Benefits:** By participating in the DCAP, an Employee may use pre-tax dollars to pay for qualifying Dependent Care Expenses that are not otherwise reimbursed.

**B. What are "Health FSA Benefits"?**

If you elect Health FSA Benefits, you will execute and submit an enrollment form/salary reduction agreement ("Enrollment Form") and agree to have a portion of your pre-tax compensation deducted from your pay and contributed to a fund that will be used to reimburse you as you incur Medical Care Expenses that are not covered by your health insurance plan or otherwise reimbursed. Please see Exhibit B for a detailed description of Medical Care Expenses.

Once you incur Medical Care Expenses, the Plan Sponsor will use the funds deducted from your pay to reimburse you for the cost of the Medical Care Expenses. This arrangement is beneficial to you because the reimbursement to you is nontaxable, saving you from paying Social Security and income taxes on the amounts deducted from your compensation.

Health FSA Benefits are intended to cover the costs of Medical Care Expenses not previously reimbursed and that will not be reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

**1. How are my Health FSA Benefits paid?**

When you complete the Enrollment Form, you must specify the total amount that you would like to have deducted from your compensation to pay for Medical Care Expenses incurred during the Plan Year. The total amount to be set aside during a Plan Year will be divided by the number of payroll periods in the Plan Year to which the Enrollment Form applies and converted through equal payroll deductions. From then on, a contribution toward this annual total will be deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by the Plan Sponsor).

For example, suppose that you elected to be reimbursed up to \$1,000 per year for Medical Care Expenses, and that you chose no other benefits under the Plan. If you were to pay all of your contributions, your Health FSA

Account would be credited with a total of \$1,000 during the Plan Year. If you were paid on a biweekly basis, your Health FSA Account would reflect that you would pay \$38.50 for the first pay period and \$38.46 for each of the remaining 25 pay periods for the Health FSA Benefits that you elected.

All amounts deducted from your earnings will be credited each pay period recorded in an account called a *Health Flexible Spending Account* set up in your name. Health Flexible Spending Accounts are merely recordkeeping accounts used to keep a record of contributions as well as reimbursements to which Participants are entitled. Please note that all reimbursements are paid from the general assets of the Plan Sponsor and contributions will not bear interest. The Plan Sponsor makes no contribution to your Health FSA Account.

## **2. What are the maximum Health FSA Benefits that I may elect?**

You may choose any amount of Medical Care Expense reimbursement that you desire under the Health FSA, subject to the maximum reimbursement amount of \$5,000.00 per Plan Year. You will be required to pay the annual Health FSA contribution equal to whatever coverage level you choose.

## **3. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?**

As long as you continue to pay the agreed-upon contributions, the total amount of the coverage that you elected for the Plan Year (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for eligible Medical Care Expenses incurred during the Plan Year.

For example, suppose that you elected \$1,000 of coverage and contributed to your Health FSA Account (as described above) during January and February. By February 24 you would have contributed \$153.88. Suppose also that you haven't made any prior claims for reimbursement during the calendar year, but on February 26 you incur a Medical Care Expense in the amount of \$300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, \$300 would be available to you for that expense, even though you have only contributed \$153.84 to your Health FSA Account at the time.

## **4. When must the Medical Care Expenses be incurred?**

For Medical Care Expenses to be reimbursed to you from your Health FSA for the Plan Year, they must have been incurred during the Plan Year or an extension period of two and one-half months immediately following the Plan year (the "Extension Period").

A Medical Care Expense is incurred when the service that gives rise to the expense is provided, regardless of when you pay for the Medical Care Expense.

Certain services, such as orthodontia or fertility treatment programs, are performed over a time period that may span multiple Plan Years. If the substantiation that you provide in support of your claim is sufficiently detailed to clearly indicate the charge for each specific service within a treatment program, the Plan will reimburse you for each specific charge as it is incurred. If, as in most cases, one fee applies to the entire treatment program, then reimbursement will be equally apportioned over the treatment period.

## **5. How can I take advantage of the Extension Period?**

The Plan allows you to be reimbursed from unused amounts remaining in your Health FSA at the end of a Plan Year for Medical Care Expenses incurred during the Extension Period following the end of the Plan Year. The Extension Period will begin on the date immediately following the end of the Plan Year and will end on **no later than the 15<sup>th</sup> day of the third calendar month following the Plan Year**. The Extension Period under the Plan will be January 1, 2009 through March 15, 2009 and will apply to unused amounts remaining in your Health FSA Account on December 31, 2008.

In order to take advantage of the Extension Period, you must be:

- A Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the Extension Period relates; or
- A “Qualified Beneficiary” who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the Extension Period relates (See Section VI).

The following additional rules will apply to Medical Care Expenses that are incurred during the Extension Period or are submitted after the close of the Plan Year in which they were incurred:

- Medical Care Expenses incurred during the Extension Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.

For example, assume that \$200 remains in your Health FSA Account at the end of the Plan Year running from January 1-December 31, 2006 and that you have also elected \$2400 of Health FSA coverage for 2007. If you submit a \$500 Medical Care Expense that was incurred on January 15, 2007, \$200 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2006 Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2007 Plan Year.

- Claims will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$500 Extension Period expense, you discover \$200 of 2006 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2006 expenses. The Plan will not reprocess the \$500 Extension Period expense so as to pay it entirely from your 2007 Health FSA amounts. For this reason, if you have Health FSA coverage for both the prior and current years, you may want to wait to submit Medical Care Expenses you incur during the Extension Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

- Expenses incurred during a Plan Year or the Extension Period must be submitted by March 31st following the close of the Plan Year in order to be considered for reimbursement from amounts remaining at the end of that Plan Year. Unused amounts remaining in a Participant's Health FSA Account at the end of the Plan Year's Extension Period that are not applied to pay expenses submitted on or before the deadline of March 31st after the expiration of the Plan Year will be forfeited.
- You may not be reimbursed for any expenses incurred before the Plan became effective, before your Enrollment Form became effective, after the close of the Plan Year and corresponding Extension Period, or after your separation from service (except for Continuation Coverage, as described below).

## **6. What must I do to be reimbursed for Medical Care Expenses?**

To be reimbursed for a Medical Care Expense that is eligible for payment:

- Submit a claim to the Plan Administrator on a *Health FSA Reimbursement Claim Form* that will be supplied to you. It is not necessary for you to have actually paid for a Medical Care Expense in order to submit a claim; you must only have *incurred* a qualifying expense, which is not being paid for or reimbursed from any other source.
  - Include written statements and/or bills from independent third parties including a description of the Medical Care Expense, the date it was incurred, and the cost along with the Health FSA Reimbursement Claim Form. Generally, such documentation will include an Explanation of Benefits (EOB) Form from the medical insurance carrier or a bill from a doctor's office indicating the amount you are required to pay.

- Canceled checks and credit card or cash receipts are not acceptable forms of substantiation since they only indicate that an amount was paid on a particular date. Rather, you must submit proof that you incurred an obligation to pay for a qualifying Medical Care Expense that was performed on a specific date during the Plan Year and while you were a Participant.
  - You will have until March 31<sup>st</sup> after the end of the Plan Year to submit a claim for reimbursement for Medical Care Expenses incurred during that Plan Year or the Extension Period, as applicable.
  - Further details about what must be provided are contained in the Health FSA Reimbursement Claim Form.
- If you paid the contributions for the Health FSA coverage you elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Claim Form (subject to a 15-day extension for matters beyond the Plan Administrator's control).
  - You will not be reimbursed for any expenses incurred in excess of the total annual reimbursement amount elected.
  - You will be notified in writing if any claim for benefits is denied.

If the Plan Sponsor implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (such as, co-payments for prescription drugs). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. If you use an electronic payment card you still must document and substantiate expenses as required by the Plan and the Health FSA. You will receive more information from the Plan Sponsor if an electronic payment card is issued to you.

**7. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?**

Yes. If the total Medical Care Expenses that you incur during the Plan Year (or the Extension Period, as applicable) are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the balance left in your Health FSA Account. This is commonly known as the "use-it-or-lose-it" rule. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any expenses that were not incurred for Medical Care Expenses during the Plan Year or the Extension Period. You will forfeit any amounts in your Health FSA Account that are not applied to Health FSA Benefits for any Plan Year or the Extension Period within ninety-one (91) days after the end of the Plan Year for which the election was effective.

**8. What will happen to forfeited amounts?**

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Plan Sponsor as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering a Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

**C. What are "DCAP Benefits"?**

If you elect DCAP Benefits, you agree to have a portion of your pre-tax compensation contributed to a fund to be used to reimburse you for eligible Dependent Care Expenses that are not reimbursed elsewhere. Specifically, if you elect DCAP Benefits, you will execute and submit an Enrollment Form with your Plan Sponsor and agree to a compensation reduction to pay for Dependent Care Expenses instead of receiving a corresponding amount of your regular pay. In return, you may be reimbursed from the Plan for certain eligible Dependent Care Expenses. This arrangement helps you because the coverage that you elect is nontaxable, which saves you Social Security and income taxes on the amounts deducted from your compensation.

"*Dependent Care Expenses*" are employment-related expenses incurred on behalf of any Dependent who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each Dependent for whom you incur the expenses must be a Qualifying Individual; he or she must be:
  - a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, your child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
  - your Spouse or a person who is your Dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts:
  - your earned income for the calendar year (after your compensation reductions under the Plan);
  - the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student); or
  - either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status, as described further described in Section III.C.2. below).
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.
- You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.
- The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your Dependent under federal tax law; or (2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

## 1. How are my DCAP Benefits paid?

When you complete the Enrollment Form, you must specify the total amount that you would like to have deducted from your compensation to pay for Dependent Care Expenses incurred during the Plan Year. The total amount to be set aside during a Plan Year will be divided by the number of payroll periods in the Plan Year to which the Enrollment Form applies and converted through equal payroll deductions. From then on, a contribution toward this annual total will be deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by the Plan Administrator).

For example, suppose you have elected to be reimbursed for \$2,600 per year for Dependent Care Expenses, and that you have chosen no other benefits under the Plan. Your DCAP Account would be credited with a total of \$2,600 by the end of the Plan Year. If you are paid bi-weekly, your DCAP Account would reflect that you have paid \$100 (\$2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

All amounts deducted from your earnings will be credited each pay period recorded in an account called a *DCAP Account* set up in your name. DCAP Accounts are merely recordkeeping accounts used to keep a record of contributions as well as reimbursements to which Participants are entitled. Please note that all reimbursements are paid from the general assets of the Plan Sponsor and contributions will not bear interest. The Plan Sponsor makes no contribution to your DCAP Account.

## 2. What are the maximum DCAP Benefits that I may elect?

You may elect any amount of Dependent Care Expense reimbursement that you desire under the DCAP, subject to the maximum reimbursement amounts described below. You will be required to pay the annual DCAP contribution equal to the coverage level you have chosen.

The amount of Dependent Care Expense reimbursement that you choose cannot exceed the maximum amount specified in Code § 129. The maximum amount is currently \$5,000 for a calendar year if any of the following applies:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes, for more than half of the taxable year, the principal place of abode of a qualifying individual (that is, the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or
- you are single or are the head of the household for federal income tax purposes.

If you are married and reside with your Spouse, but you file a separate federal income tax return, then the maximum DCAP Benefit that you may elect is \$2,500 for a calendar year.

The above maximum (\$5,000 or \$2,500 for a calendar year, as applicable) applies to the amount that you may elect under this DCAP and any DCAP of your Spouse. However, the above maximum is just the largest amount that is possible; the election amount that applies to you may be less than the above maximum because of other limitations (as described in the definition of "Dependent Care Expenses" set forth in this Section III.C. above (for example, reimbursement cannot exceed the amount of your or your Spouse's earned income for the Plan Year).

## 3. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. Using the example set forth above, suppose that you incur \$1,500 of Dependent Care Expenses by the end of March. At that time, your DCAP Account would only have been credited with \$600 (\$100 times 6 pay periods), so only \$600 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait for reimbursement of the remaining \$900 of Dependent Care Expenses until after you had received the appropriate credits to your DCAP

Account. Note, however, that the earned income limitations described in this Section II.C. above (see the definition of "Dependent Care Expenses") must also be met.

#### **4. When must the Dependent Care Expenses be incurred?**

Dependent Care Expenses must have been incurred during the Plan Year. A Dependent Care Expense is incurred when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. Note that if you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for your child's daycare on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Enrollment Form became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described in Section II.C.6. below).

#### **5. What must I do to get reimbursed for my Dependent Care Expenses?**

To be reimbursed for Dependent Care Expense that is eligible for payment:

- Submit a claim to the Plan Administrator on a *DCAP Reimbursement Claim Form* that will be supplied to you. It is not necessary for you to have actually paid the bill in an amount due for Dependent Care Expenses in order to be reimbursed; only for you to have *incurred* a qualifying expense, which is not being paid for or reimbursed from any other source.
  - Include with the DCAP Reimbursement Claim Form written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and the amount of such Dependent Care Expenses; or
  - Have the dependent care provider sign, date and list its federal tax identification number on the DCAP Reimbursement Claim Form.
- Further details about what must be provided are contained in the DCAP Reimbursement Claim Form.
- You will have until March 31st following the end of the Plan Year to submit a claim for reimbursement for Dependent Care Expenses incurred during that Plan Year.
- If there are enough contributions in your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Claim Form (subject to a 15-day extension for matters beyond the Plan Administrator's control).
- If a claim is for an amount that is more than your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate.
- You cannot be reimbursed for any total expenses above your available annual credits to your DCAP Account.
- You will be notified in writing if any claim for benefits is denied.

#### **6. Is there any risk of forfeiting the amount that I elect for DCAP Benefits?**

Yes. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any expenses that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. You will forfeit any amount allocated to your DCAP Account if that amount has not been applied to DCAP Benefits for any Plan Year by ninety-one (91) days after the end of the Plan Year for which the election was effective.

#### **7. What will happen to forfeited amounts?**

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Plan Sponsor as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the

DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

Also, any DCAP Account benefit payments that are unclaimed (for example, un-cashed benefit checks) by the end of the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred will be forfeited and applied as described in the Plan.

**8. If I elect DCAP Benefits, can I still claim the Dependent Care Credit on my federal income tax return?**

You may not claim any other tax benefit for the amount of your pre-tax compensation reductions under the DCAP, although the balance of your Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Code § 21 (*Dependent Care Credit*). For example, if you elect \$3,000 of coverage under the DCAP and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, you could count the excess \$2,000 when calculating the Dependent Care Credit if you have two or more Dependents. Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the Plan.

**9. What is the Dependent Care Credit?**

As described in Section 8, the Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability under the Code.

For more information about how the Dependent Care Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor.

**D. Is there additional information I should know about the Benefits?**

**Qualified Medical Child Support Order.** The components of this Plan that are group health plans extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

**Newborns' and Mothers' Health Protection Act of 1996.** Group health plans and health insurance issuers **generally** may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

**Women's Health and Cancer Rights Act.** Group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient, for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. This coverage may only be subject to the annual deductions and coinsurance provisions that apply to similar benefits.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits: (1) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (2) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

## **IV. PLAN OPERATION**

### **A. How does the Plan operate?**

Before the start of each Plan Year, Employees may elect to participate in the Plan by completing, signing and submitting an Enrollment Form to the Plan Sponsor. The Plan Administrator will maintain separate bookkeeping accounts in Participants' names to record the amounts withheld from pay.

The amount of pay reduced under the Enrollment Form shall be divided by the number of payroll periods in the Plan Year to which the Enrollment Form applies and converted through equal payroll deductions.

### **B. What tax savings would I gain by participating in the Plan?**

You save both federal income tax and FICA (Social Security) taxes by participating in the Plan.

The specific amount a Participant actually saves will depend on which family members are covered, the total family income, and the tax deductions and exemptions claimed. In addition, pay reductions reduce earned income, which can impact the earned income credit for eligible taxpayers. Finally, Plan participation may also result in state tax savings.

### **C. What is the role of the Plan Administrator?**

The Plan Sponsor has appointed MVP Select Care, Inc. to be the Plan Administrator. The Plan Administrator is responsible for the management, operation and administration of the Plan. Specifically, the Plan Administrator is authorized to: (1) make and enforce any rules and procedures it determines are necessary or proper for the operation of the Plan; (2) interpret Plan terms and determine benefit eligibility under the Plan (including questions of fact); and (3) determine benefit eligibility (including determining questions of fact). The Plan Administrator's decisions are final and binding, to the extent permitted by applicable law.

### **D. What are the "Plan Year" and the "Open Enrollment Period"?**

The Plan Year is the 12-month period beginning on each January 1 and ending on December 31. Plan Year is the same for the Plan, the Health FSA, and the DCAP.

The Open Enrollment Period for a Plan Year generally will be in November immediately preceding the beginning of the Plan Year. You will be notified, in advance, of the duration of the Open Enrollment Period.

### **E. Will I pay any administrative costs under the Plan?**

No. The cost is paid in part by the use of forfeitures, if any, and any remaining costs associated with administering the Plan are paid entirely by the Plan Sponsor.

### **F. How long will the Plan remain in effect?**

Although the Plan Sponsor expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

### **G. How will participating in the Plan affect my Social Security and other benefits?**

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits, which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

## **V. ENROLLMENT PROCESS**

**A. What procedures must I follow to enroll in the Plan as a new Employee?**

When you first become eligible to participate in the Plan, you may enroll by completing, signing and submitting to the Plan Sponsor an Enrollment Form in the time frame specified in the enrollment materials. The Enrollment Form includes your personal choices for participation in each of the available Benefits and authorizes the Plan Sponsor to deduct a portion of your compensation from your paycheck on a pre-tax basis and set it aside to be used to pay for the selected Benefits.

**B. What procedures must I follow to re-enroll for subsequent Plan Years?**

For subsequent Plan Years, the Enrollment Form will be made available to you by the first day of the Open Enrollment Period. You must complete the Enrollment Form and return it to the Plan Administrator during the Open Enrollment Period.

**C. Can the Plan Administrator reject, revoke or modify my elections?**

Yes. The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

**D. What will happen if I fail to enroll in the Plan as a new Employee?**

IT IS VERY IMPORTANT THAT YOU COMPLETE YOUR ELECTION FORM ON TIME EACH YEAR. As a new Employee, if you do not complete, sign and file an Enrollment Form with the Plan Administrator within the time period specified in the enrollment materials, you will not be able to participate in either the Health FSA or the DCAP until the next Open Enrollment Period unless a Change in Election Event (see Section V.F.) occurs.

**E. What will happen if I fail to re-enroll in the Plan as a Participant?**

If you do not reelect coverage under either the Health FSA or the DCAP, you will be automatically deemed to have elected not to participate in Health FSA or DCAP at all for the following Plan Year.

**F. Can I change my election for Benefits or compensation reduction amounts during a Plan Year?**

Generally, you cannot change your election to participate in the Plan or vary the compensation reduction amounts you have selected during the Plan Year. Of course, you can change your elections for Benefits and compensation reduction amounts during the Open Enrollment Period, but that will apply only for the upcoming Plan Year.

Participants can change their elections under the Plan during a Plan Year if any of the "Change in Election Events" described below occur and certain other conditions are met:

- **FMLA Leaves of Absence.** If you go on a qualifying leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by the FMLA, your Plan Sponsor will continue to maintain your Health FSA Benefits on the same terms and conditions as if you were still active.
  - Paid FMLA Leave. Your Plan Sponsor may require Participants to continue all health insurance benefits and Health FSA Benefits coverage while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax compensation reduction basis if that is what was used before the FMLA leave began).
  - Unpaid FMLA Leave. If you are going on unpaid FMLA leave, and you opt to continue your Health FSA Benefits, then you may pay your share of the contribution in one of three ways: (1) with after-tax

dollars while on leave; (2) with pre-tax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of the contribution for the expected duration of the leave on a pre-tax compensation reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation would normally be available to you (note: pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year)); or (3) by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave, or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Plan Sponsor's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

- **Non-FMLA Leaves of Absence.** If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due for you will be paid by prepayment before going on leave, after-tax contributions while on leave or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply (see below).
- **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Health FSA Benefit, you may change your election to provide coverage for the Dependent child. If such judgment, decree or order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child if such new coverage is, in fact, provided for the child.
- **Medicare or Medicaid.** If you, your Spouse, or your Dependent (who is also a Participant) becomes enrolled in Medicare or Medicaid (other than with respect to vaccines), you may cancel your Health FSA coverage completely. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase Health FSA Benefits.
- **Change in Status/Health FSA.** Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following Change in Status events:
  - death of your Spouse;
  - divorce, legal separation, annulment;
  - death of your Dependent;
  - change in employment status such that you become ineligible for Health FSA coverage; or
  - a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g. on account of attaining a certain age).

- **Change in Status/DCAP.** With respect to DCAP Benefits, if one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (2) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). "Spouse" means the person who is legally married to you and is treated as a spouse under the Code;
  - A change in the number of your Dependents (including birth, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
  - Any of the following events that changes your employment status or that of your Spouse or Dependent and affects benefit eligibility under a cafeteria plan (including this Plan) or any other of your employee benefit plans or those of your Spouse or a Dependent. Such events include any of the following: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
  - An event that causes a Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, ceasing to be a student, or similar circumstance); and
  - A change in your place of residence or that of your Spouse or a Dependent.
- **DCAP Cost Changes.** If the cost charged to you for DCAP Benefits significantly increases during the Plan Year, then you may choose to make a corresponding increase in your contributions, provided, the cost change is imposed by a dependent care provider who is not your relative.
  - **DCAP Coverage Changes.** You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

## VI. COBRA CONTINUATION COVERAGE

### A. What is "COBRA Continuation Coverage" and how does it work?

Required under federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)), COBRA Continuation Coverage is a temporary extension of coverage under any component medical benefit plan that takes effect when a "Qualified Beneficiary" would otherwise lose coverage. COBRA continuation coverage may become available to you or your Spouse or Dependent when you (or they) would otherwise lose group health benefits due to a "Qualified Event." The only component medical benefit plan under the Plan is the Health FSA Benefit. COBRA continuation of that benefit is available to you under the Plan on the limited basis described below.

More specifically, COBRA Continuation Coverage is a continuation of the group health coverage that was in place for a Qualified Beneficiary the day before the occurrence of a “Qualifying Event” that would have otherwise caused the Qualified Beneficiary’s coverage to end.

A Qualifying Event is defined as:

- termination of your employment (other than by reason of gross misconduct);
- reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent’s ceasing to be a Dependent.

To be eligible for COBRA Continuation Coverage of the Health FSA, it will be the Participant’s obligation to inform the Plan Administrator of the Qualifying Event (other than a change in employment status or death), within 30 days of its occurrence. The Plan Administrator, in turn, will furnish the Participant (and the Spouse, as the case may be) with separate, written options to continue the Health FSA. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

With respect to the Health FSA, the availability of COBRA Continuation Coverage is limited to situations in which the amount you could receive as reimbursement under the Health FSA for the remainder of the Plan Year exceeds the amount you would have to pay in COBRA Continuation Coverage premiums for group health coverage during the remainder of that Plan Year. When available, Continuation Coverage under the Health FSA terminates at the end of the Plan Year and cannot be continued for the next Plan Year.

With respect to COBRA Continuation Coverage of your group health plan, please refer to the summary plan description for that plan.

## **VII. APPEALS**

### **A. What happens if my claim for reimbursement is denied?**

If a claim for reimbursement under the Health FSA or DCAP component of the Plan is wholly or partially denied, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. In the event a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will describe:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator’s decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

### **B. Can I appeal a claim denial?**

If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court.

Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Plan Administrator (or other entity designated by the Plan Administrator) in a reasonable time not later than 60 days after the Plan Administrator receives your request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- with respect to the Health FSA, if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA § 502(a) (where applicable).

## **VIII. ADDITIONAL PLAN INFORMATION**

### **A. What are my ERISA Rights?**

The Health FSA Benefit is governed by Employee Retirement Income Security Act of 1974 (ERISA). As a Participant in an ERISA-covered benefit plan, you are entitled to certain rights and protections under ERISA:

**1. To receive information about the Plan and the Benefits.** As a Plan Participant you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

- 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.
- 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 Plan 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.

**2. Continue Group Health Plan Coverage.** You have a right to continue health insurance coverage for yourself, spouse and 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 Plan Documents for the rules governing your COBRA Continuation Coverage rights.

**3. HIPAA Privacy Rights.** Under the provisions of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Plan Sponsor (or medical insurers) that outlines its health privacy policies.

**4. Prudent Action by Plan Fiduciaries.** In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries.

**5. No Discrimination.** No one, including the Plan Sponsor, your union 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.

**6. Right to Review.** 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.

**7. Enforce Your Rights.** Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual representative 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 a certain amount for each day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 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.

**8. Assistance With Your Questions.** If you have questions about the Plan, you should contact the Plan Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **B. What other general information should I know?**

### **General Plan Information**

- The name of the Plan is **MARIST COLLEGE FLEXIBLE REIMBURSEMENT PLAN**.
- Your Plan Sponsor has assigned Plan Number 503 to your Plan.

- The Plan was originally established on August 1, 1998. This Summary Plan Description was effective on January 1, 2008.
- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31. The date of the end of the year for maintaining the fiscal year Plan records is December 31.
- The Plan is to be a "cafeteria plan." As defined in Section 125 of the Internal Revenue Code ("Code"), an accident or health plan described in Section 105 and 106 of the Code or a group term life insurance plan described in Code Section 79, as applicable. Note that your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC). The PBGC, an agency of the federal government, generally requires or provides insurance for certain pension plans only.
- The Plan provides for pre-tax (and after-tax, if applicable) contributions by or on behalf of Participants for the purpose of obtaining benefits under the Plan.

### **Plan Sponsor Information**

- Your Plan Sponsor's name and address are:  
 Marist College  
 3399 North Road  
 Poughkeepsie, NY 12601
- The Plan Sponsor's federal employee tax identification number (EIN) is: 14-1442493

### **Plan Administrator Information**

- The name, address, and business telephone number of the Plan Administrator are:  
 MVP Select Care, Inc.  
 625 State Street  
 P.O. Box 1464  
 Schenectady, NY 12301  
 (800) 788-8771
- The Health FSA component of the Plan is a group health plan and a contract administration plan. A third-party administrator processes claims for the Plan, but the Plan Sponsor pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

### **Service of Legal Process**

The name and address of the Plan's agent for service of legal process is:

Name of Plan Sponsor  
 Marist College  
 3399 North Road  
 Poughkeepsie, NY 12601

\* \* \* \*

## EXHIBIT A GLOSSARY

“**Benefit**” means any of the benefit programs available under the Plan.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Employee**” means (1) an employee of Plan Sponsor who is eligible to participate in the Plan, or (2) in the event Plan Sponsor is a union or association, a member of Plan Sponsor who is eligible to participate in the Plan.

“**Enrollment Form**” means an enrollment form/salary reduction agreement used to elect your personal choices for participation in each of the available Benefits and authorizes the Plan Sponsor to deduct a portion of your compensation from your paycheck on a pre-tax basis and set it aside to be used to pay for the selected Benefits.

“**Medical Care Expenses**” means those expenses so defined on Exhibit B.

“**Open Enrollment Period**” for a Plan Year generally will be in November immediately preceding the beginning of the Plan Year.

“**Participant**” means an Employee or an Employee’s Spouse or Dependent who meets the Plan’s eligibility requirements and has enrolled in the Plan.

“**Plan Administrator**” means MVP Select Care, Inc.

“**Plan**” means this Marist College Flexible Reimbursement Plan.

“**Plan Sponsor**” means Marist College.

“**Plan Year**” means the 12-month period beginning on each January 1 and ending on December 31.

**EXHIBIT B  
MEDICAL CARE EXPENSES**

"Medical Care Expenses" means expenses incurred by you, your Spouse or your Dependents for "medical care" as defined in Code § 213, as amended or modified from time to time. Under the tax laws, Medical Care Expenses includes expenses for certain over the counter drugs and medicines as well as expenses for certain prescription drugs.

Generally, this means an item for which you could have claimed a Medical Care Expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source.

Table 1 lists over-the-counter items that are generally reimbursable.

Table 2 lists over-the-counter items that are generally reimbursable under certain conditions.

Table 3 lists certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213, and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213 and other requirements for reimbursement under the Health FSA.

The information set forth on this Exhibit B is not exhaustive and is subject to change. For more information about what items are, and are not, Medical Care Expenses, consult a tax advisor.

**TABLE 1: Over-the-Counter Items that are Reimbursable (list is not exhaustive)**

**---Small quantities of the following items do not require a physician's letter to be reimbursed by the Plan**

<p>Allergy Medicine or Cold &amp; Flu Medicine, containing analgesic, antihistamine or antitussive formulation</p> <p>Antibacterial cream</p> <p>Balm for treating muscle and joint pain</p> <p>Burn cream or ointment containing antibiotic</p> <p>Diaper rash ointment</p> <p>Foot preparations containing antifungal formulation</p> <p>Gastrointestinal medicine containing antacid, antifatulent, antidiarrheal, antiemetic, laxative or fecal softener</p>	<p>Hemorrhoid treatment, including suppositories and creams</p> <p>Insect bite medication containing anti-infective agent</p> <p>Nicotine gum or patches for stop-smoking purposes</p> <p>Ophthalmic preparation</p> <p>Pedialyte or similar formulation for treating an ill child</p> <p>Pain reliever containing aspirin, ibuprofen or acetaminophen</p> <p>Respiratory product containing sympathomimetic formulation</p> <p>Sinus medicine or nasal sinus spray</p> <p>Wart removal medication</p>
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**TABLE 2: Over-the-Counter Items that may be Reimbursed Under Certain Conditions (list is not exhaustive)**

<p>Reimbursement for the following items is permitted only in the event the claim is accompanied by a letter from a licensed physician recommending the use of these items for the treatment of a specific medical condition, not for general health, and for a specified duration of time. The letter must specify the condition being treated and the duration of the treatment program.</p>	<p>Fiber supplements and digestive aids</p> <p>Herbal medicines and vitamins</p> <p>Hormone therapy to treat symptoms of menopause</p> <p>Prenatal vitamins</p> <p>Sedatives and Hypnotics</p> <p>Weight-loss drugs used to treat a specific disease (including obesity). Items that replace normal food consumption are not reimbursable.</p>
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**TABLE 3: Exclusions - Medical Expenses That Are Not Reimbursable (list is not exhaustive)**

**---The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under regulations governing Health FSAs:**

<p>Over-the-counter drugs and pregnancy testing kits except as indicated below in Sections 22(b) and 22(c)</p> <p>Health insurance premiums that you or your Spouse pay for coverage under another health plan.</p> <p>Long-term care services</p> <p>Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.</p> <p>The compensation expense of a nurse to care for a healthy newborn at home.</p> <p>Funeral and burial expenses.</p> <p>Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).</p> <p>Home or automobile improvements.</p> <p>Custodial care.</p> <p>Costs for sending a child restricted from conventional schooling to an alternative or special school for benefits that the child may receive from the course of study and disciplinary methods.</p>	<p>Health club or fitness program dues.</p> <p>Social activities, such as dance lessons (even though recommended by a physician for general health improvement).</p> <p>Bottled water.</p> <p>Maternity clothes.</p> <p>Diaper service or diapers.</p> <p>Cosmetics, oral rinses, shampoo, skin moisturizers, soap, toiletries, toothbrushes, toothpaste, etc.</p> <p>Uniforms or special clothing, such as maternity clothing. Automobile insurance premiums.</p> <p>Special foods</p> <p>Automobile transportation expenses, including transportation expenses to receive medical care.</p> <p>Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.</p> <p>Any item that does not constitute "medical care" under Code § 213.</p> <p>Any item that is not reimbursable under Code § 213 due to applicable regulations</p>
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