

ST. FRANCIS HEALTH SERVICES OF MORRIS, INC.
SELECTACCOUNT FLEXIBLE BENEFIT PLAN
MEDICAL FSA SUMMARY

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1. INTRODUCTION

The Company's SelectAccount Flexible Benefit Plan (the "Plan") permits Eligible Employees to choose to pay for certain benefits on a pre-tax basis.

This *Summary* describes the Medical Flexible Spending Account ("Medical FSA") Benefit Option under the Plan. Through the Medical FSA, you can pay Medical Expenses not covered by insurance for yourself and eligible family members on a pre-tax basis. This will generally result in a tax savings and increase your spendable income.

Refer to our *SelectAccount Flexible Spending Accounts Quick Start Guide* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at www.SelectAccount.com to estimate your tax savings.

The tax benefit you experience will depend on the benefits you elect, as well as other factors that affect the amount of taxes you pay. Although participating in the Plan can provide significant tax advantages, there may be tax disadvantages to participating in the Plan based on your particular situation. You may wish to consult with your tax advisor.

2. DETAILS REGARDING THE MEDICAL FSA BENEFIT

(a) **Medical Expenses Eligible for Reimbursement.** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Benefit Option.

(b) **Your options for medical FSA reimbursements:**

- **Debit Card.** If you have an HSA and you open a medical FSA with SelectAccount, you have the option to enroll with a SelectAccount debit card. Once activated, your medical FSA debit card can be used for eligible medical expenses up to your available medical FSA balance.

It's important to note if you are using your medical FSA debit card and later elect to use the "Crossover" feature (see below), your debit card will be cancelled as both the debit card and crossover cannot be active at the same time. If you later decide to switch back and request a debit card, your crossover will be discontinued and you will receive a new card. If you find that you prefer crossover, you can discard the debit card and enroll in crossover at www.selectaccount.com.

- **Crossover.** If you do not have a HSA and you participate in a Blue Cross Blue Shield of Minnesota group medical plan, you can elect to have the group plan automatically submit requests for reimbursement of patient responsibility eligible expenses (e.g., deductible amounts) to your FSA, using "crossover". If you are covered under more than one major medical plan, you should not participate in the crossover program to ensure claims are adjudicated correctly. Please note that crossover and debit cards will not work at the same time.

Manual Claim. To receive reimbursement for Medical Expenses, you must submit a completed claim form and independent third-party documentation of the expense (section 9).

- (c) **Expenses cannot be reimbursed From Any Other Source, Including Tax Credits or Tax Deductions.** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.
- (d) **Limitations for HSA and Medical FSA Combination.** If you elect to participate in both the HSA and the Medical FSA benefits under this Plan, your Medical FSA is automatically limited to reimbursement of the following HSA-Compatible expenses: Vision and Dental; Post Deductible Medical. You may also choose to participate in an HSA-Compatible Medical FSA to maintain your eligibility and/or the eligibility of your spouse to participate in an HSA outside of this Plan. If you have not elected HSA coverage under this Plan, however, you must notify SelectAccount that you wish to participate in an HSA-Compatible Medical FSA.

3. **ELIGIBLE EMPLOYEES**

Only Eligible Employees may participate. Refer to the *Plan Specifics* for details.

4. **DEPENDENTS**

- (a) To use the Medical FSA for reimbursement of medical expenses incurred by you for yourself or a family member who qualifies as your “Dependent”.
- (b) “Dependent” includes: (i) your spouse (who is of the opposite sex and to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

5. **ENROLLMENT**

- (a) **Initial Enrollment.** You must enroll within 30 days of becoming an Eligible Employee and satisfying the Service Requirement, if any. Refer to the *Plan Specifics* for the Service Requirement.
- (b) **Annual Open Enrollment.** If you do not enroll when you are first eligible, you must wait until the next Open Enrollment Period for another chance to participate (unless you experience an “Election Change Event” and make a “Qualifying Election Change,” as discussed later in this *Summary*). Federal tax law prohibits any other mid-year enrollment. The Open Enrollment Period for each Plan Year will be

determined by the Plan Administrator.

- (c) **Enrollment Procedure.** The Plan Administrator will provide enrollment instructions. You must complete your enrollment within the time specified by the Plan Administrator.
- (d) **Medical FSA Election.** You must indicate the amount you want to contribute, if any, to a Medical FSA when you enroll.

6. **WHEN PARTICIPATION BEGINS**

Your participation begins on the Entry Date stated in the *Plan Specifics*.

7. **ELECTION CHANGES DURING THE PLAN YEAR**

- (a) **Qualifying Election Changes.** Your election for any Plan Year cannot be changed during the Plan Year unless you experience an Election Change Event and make an election change that is on account of and consistent with the event (called a “Qualifying Election Change”). For complete details, request a copy of the Plan Document from the Plan Administrator or contact the Claims Administrator for assistance.
- (b) **Examples.**
 - (1) If you get married, add a child to your family through birth or adoption or have a child who gains dependent status, you can increase your Medical FSA election.
 - (2) If you divorce, a child no longer qualifies as your dependent, or your dependent dies, you can decrease your Medical FSA election.
 - (3) If your spouse or a dependent starts or ends a job or increases or decreases his or her work hours and gain or lose eligibility for employer-sponsored health insurance or health flexible spending account coverage as a result, you can make a corresponding increase or decrease your Medical FSA coverage through this Plan.
 - (4) If a court order requires you or another person to provide health coverage for an eligible child, a corresponding change can be made in your Medical FSA contributions.
 - (5) If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage, a corresponding change can be made in the contributions to your Medical FSA.
 - (6) You may change your Medical FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.
- (c) **You Cannot Elect An Amount Less than the Amount Already Reimbursed.** An

election change will not be consistent with an Election Change Event if the new amount elected is less than the amount already reimbursed from the Medical FSA for the Plan Year.

- (d) **Time Limit for Making Election Change.** To change your election, you must request an election change not later than 30 days after the Election Change Event (even if you are on leave at the time). You cannot change your election more than 30 days after an Election Change Event.
- (e) **Election Change Process.** The Plan Administrator will provide instructions for requesting an election change. The Plan Administrator will determine whether an election change is permitted.

8. **PARTICIPATION DURING A LEAVE OF ABSENCE**

Coverage will continue under this Plan during a leave of absence in accordance with the Company's leave policies and the terms and conditions of the Plan. If there is a conflict between the information provided in this section and the Company's leave policies, the Company's leave policies will control. The Company must approve your leave.

You will be required to make your premium/contribution payments ("payments") for coverage to continue. If you do not make the required payment when due (including any grace period), the Company may retroactively terminate your coverage to the last day for which you have paid. Expenses incurred during the period for which your coverage is retroactively terminated will not be covered. The Company can recover any payments owed. Upon return to work, the payments owed will be taken from your pay.

Contact the Plan Administrator for coverage payment options.

- (a) **Paid Leave of Absence.** Your Medical FSA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay.
- (b) **Unpaid Leave of Absence.** Your right to continue Medical FSA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your Medical FSA coverage at the beginning of leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows.
 - (1) *FMLA Leave.*
 - (i) If you take FMLA leave, you may choose to continue or discontinue your Medical FSA coverage. You must notify the Company's Human Resources Department of your decision.
 - (ii) If your Medical FSA coverage terminated, it will be reinstated on return from leave. You may choose to either reinstate the per pay-period contributions you had in place prior to leave (your contribution election for the Plan Year is

reduced by the contributions you missed during your leave); or increase your per pay-period contributions for the rest of the Plan Year to make up the contributions you missed during your leave (your contribution election for the Plan Year remains the same).

- (iii) Even if you choose to increase your per pay-period contributions to make up the contributions you missed during the leave, you will still not be able to submit expenses you incurred during the leave for reimbursement. (Medical expenses you incur during the leave will be eligible for reimbursement only if you elected to continue your Medical FSA in advance of your leave.)
- (2) *Military Leave.* If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), you may continue your group health plan and Medical FSA coverage for up to 24 months during the military leave to the extent required by USERRA. You must pay for the coverage. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Company’s Human Resources Department for more information.
- (3) *Other Types of Leave.* Contact the Plan Administrator for details. If your Medical FSA coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. Medical FSA COBRA rights are explained in the *Notice* section of this *Summary*. If you do not elect to continue your coverage through COBRA, you will not be eligible to recommence participation until the next Open Enrollment Period or you experience an Election Change Event.
- (c) **Open Enrollment during Your Leave.** If the Open Enrollment Period for the next Plan Year occurs during your leave and your participation in the Plan continues, you will be able to make elections for Plan benefits for the new Plan Year in the same manner as active employees. If you do not elect Medical FSA benefits, you will not be eligible to participate in the Medical FSA in the new Plan Year, unless you experience an Election Change Event.
- (d) **Making Election Changes on Return from Leave.** Election changes other than as noted in this section will not be permitted on return from leave unless you experience another Election Change Event.

9. **OBTAINING REIMBURSEMENTS**

- (a) **Amount Available for Reimbursement.** Regardless of the amount you have contributed to the Medical FSA, the entire amount of your contribution election for the Plan Year (your Annual Contribution Election) less any prior reimbursements will be available to you at all times during the Plan Year. You will be reimbursed the entire amount of your claim, if it is less than your Annual Contribution Election.
- (b) **Expense Must Be Eligible for Reimbursement under this Plan.** The expense must qualify as medical care within the meaning of the Plan for reimbursement from the

Medical FSA. Refer to Exhibit A.

- (c) **Expense Must Have Been Incurred During Your Period of Coverage for Plan Year.** You may only use your Medical FSA to pay for Medical Expenses that you incurred during the Plan Year and any Grace Period, if any, following the Plan Year. Expenses incurred during one Plan Year cannot be reimbursed from contributions in another Plan Year, except that expenses incurred during a Grace Period can be reimbursed from the Carryover Amounts from the prior Plan Year. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter. The only exception is that expenses may be treated as incurred for orthodontia services before the services are provided if the orthodontist (following his or her normal practice) requires you to make advance payments to receive the services (*e.g.*, requires you to pay a lump sum for services to be provided that year and the next).
- (d) **Expense cannot be reimbursed out of other accounts.** Amounts contributed to the Medical FSA cannot be used to reimburse expenses from the Dependent Care FSA and vice versa.
- (e) **Claim Submission Requirements must be satisfied.**
 - (1) *Claims must be submitted to Claims Administrator.* Claims should be sent or faxed directly to the Claims Administrator at the address or number listed on the bottom of the claim form.
 - (2) *Claims must be submitted during the Plan's Claims Submission Period.* The Claims Submission Period is stated in the Plan Specifics.
 - (3) *Documentation Must Be Provided* To receive reimbursement for eligible expenses, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.
 - (4) *Claims Cannot Be Reimbursed by Health Insurance.* You cannot submit claims for reimbursement if you have already been reimbursed by health insurance or if you intend to request reimbursement.
- (f) **Method of Reimbursement.** To the extent the Claims Administrator determines that a claim is properly payable under the Plan, you will be reimbursed for the expense either through a check or via direct deposit, if you have selected that option. Reimbursements will be issued as scheduled by the Claims Administrator.
- (g) **Recovery of Improper Reimbursements.** You will be required to repay the Plan for reimbursements determined by the Claims Administrator to be ineligible for reimbursement under the Plan or otherwise improper. The Claims Administrator may use one or more of the following recovery methods: (i) you repay the amount to your

Medical FSA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursement payments to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

10. CLAIMS AND APPEAL PROCEDURE

(a) **Initial Determination on Claim for Reimbursement**

- (1) *Time Period.* Within 30 days after receipt of a claim, the Claims Administrator will make its decision on the claim. The 30-day period for the initial review determination by the Plan Administrator may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Plan; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Plan expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.
- (2) *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notification of the denial to you which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) **Appeal Rights and Procedures.**

- (1) *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Plan Administrator. You must send a written request for an appeal review to the Plan Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.
- (2) *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.

- (3) *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.
- (4) *Notice of Continued Denial.* If the denial is upheld in whole or part, the Plan Administrator will send notification of the denial to you. You will be notified of the Plan Administrator's decision on appeal in writing within 60 days after the plan administrator received your appeal. The notice will include the Plan Administrator's reason for its decision.
- (i). *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through SelectAccount. If you are not satisfied with our decision, you may elect to further appeal to SelectAccount by sending a letter within 30 days or the later of your run out end date requesting our SelectAccount Corporate Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the SelectAccount Corporate Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.

You may elect this voluntary appeal (Level Two Appeal) only after you have submitted a Level One Appeal and that appeal has been denied. You are not required to submit a Level Two Appeal prior to bringing a claim in court (the plan will not assert that you failed to exhaust administrative remedies in not submitting to a Level Two Appeal). The six-month limitation period provided in the Plan Document within which you may bring a claim to court is tolled during the time that the Level Two Appeal is pending.

11. **FORFEITURE OF ACCOUNT BALANCE**

According to federal tax law, amounts remaining in your Medical FSA after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year and any Grace Period must be forfeited. Such forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to participants. Planning

carefully on the amount to contribute to the spending accounts should help you to avoid forfeitures. Refer to our *SelectAccount Flexible Spending Accounts Employee Brochure* for a Medical FSA Election Worksheet to help you determine your contribution.

12. **TERMINATION OF PARTICIPATION DUE TO TERMINATION OF EMPLOYMENT**

- (a) **When Participation Ends.** If your employment with the Company terminates, your participation in the Plan will end as of the date of your termination of employment.
- (b) **Medical Expenses Incurred After Termination.** Medical expenses incurred after the date of your termination from employment will not be eligible for reimbursement unless you elect to continue your participation in the Medical FSA. Please refer to the COBRA continuation information in the “Notice” section below.
- (c) **Amounts Remaining After Termination.** Any amounts remaining in an account after the end of the Claims Submission Period for the Plan Year in which the termination occurred will be forfeited.
- (d) **Re-employment by a Participating Employer.** If you terminate employment and are re-employed by a Participating Employer, you may participate in the Plan as indicated in the *Plan Specifics*.

13. **OTHER REASONS FOR TERMINATION OF PARTICIPATION**

- (a) Your participation in this Plan can also end if:
 - (1) you no longer qualify as an Eligible Employee;
 - (2) your Employer stops participating in this Plan;
 - (3) you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;
 - (4) the Company terminates the Plan; or
 - (5) if the certifications you made to participate are no longer accurate
- (b) The rules discussed above for termination of participation as a result of termination of employment also apply if termination of participation occurs for other reasons.

14. **NOTICES**

- (a) **COBRA Continuation of Medical FSA Coverage.** You, your spouse or any of your dependents who lose coverage under the Medical FSA as a result of a "qualifying event" are "qualified beneficiaries" and will be eligible to continue Medical FSA coverage for the remainder of the current Plan Year as indicated in this section.
- (1) *Medical FSA Positive Balance Requirement.* To be eligible for COBRA: (i) there must be a positive balance in your Medical FSA as of the date your coverage would otherwise terminate because of a qualifying event; and (ii) the COBRA Premiums you are required to pay for the remainder of the Plan Year must exceed available reimbursements.
 - (2) *Qualifying Events.* For employees, the qualifying events are: (i) termination of employment for any reason other than gross misconduct; and (ii) a reduction in hours. For a spouse or dependent, the qualifying events may include: (i) the employee's termination of employment for any reason other than gross misconduct; (ii) the employee's loss of eligibility for coverage due to a reduction in scheduled work hours; (iii) the employee's death; (iv) the employee's divorce or legal separation; (v) a dependent child's ceasing to qualify as an eligible dependent under the Medical FSA; and (vi) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
 - (3) *Maximum COBRA Coverage Period.* COBRA continuation coverage is a temporary continuation of Medical FSA coverage. For each qualified beneficiary who elects COBRA continuation coverage, the COBRA coverage will begin on the date of the qualifying event. The maximum COBRA coverage period is through the end of the Plan Year in which the qualifying event occurred and any Grace Period following such Plan Year. The continuation coverage period is a maximum period that will be reduced as described below.
 - (4) *You Must Provide Notice to the Plan Administrator of Certain Events.* The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or the employee's death, the employer will notify the Plan Administrator of the Qualifying Event. Qualified beneficiaries must notify the Plan Administrator of the employee's divorce, legal separation or child's ceasing to qualify as a dependent under the Medical FSA within 60 days of the date of the qualifying event. If the Plan Administrator is not given the notice within 60 days, the right to continue coverage will be lost.

The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid and addressed to the Plan Administrator at the address indicated in the *Plan Specifics*.

The notice must contain the following information: (i) the name, address and Social Security Number of the employee; (ii) the name, address and Social Security Number of each qualified beneficiary (*e.g.*, employee, spouse, dependent child); (iii) a description of the qualifying event; (iv) the date of the qualifying event; and (v) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

- (5) *Type of Coverage Available for Continuation.* A qualified beneficiary may elect to continue the Medical FSA coverage in effect immediately before the qualifying event.
- (6) *Who May Elect COBRA Coverage?* An employee can make the election for himself or herself, his or her spouse, or any of his or her dependent children. If the employee does not make the election, his or her spouse can make the election for himself or herself and any dependent children. Finally, if neither the employee nor spouse makes the election for a dependent child, the dependent may make the election for him or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Medical FSA will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)
- (7) *COBRA Election Period.* After a qualifying event or receiving notice of a qualifying event (if notice is required), the Plan Administrator will send qualified beneficiaries a notice regarding COBRA election rights. Qualified beneficiaries will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue coverage. If a qualified beneficiary does not file the election within the 60-day period, he or she will lose the right to continue Medical FSA coverage. The election must be filed with the Plan Administrator at the address specified in the election form.
- (8) *COBRA Contributions.* Contributions for the continuation coverage will be on an after-tax basis unless your Compensation continues and the Plan Administrator permits pre-tax contributions for continuation coverage. A qualified beneficiary must pay the full contribution, plus a 2% administration fee, for any coverage he or she continues. He or she must make the first contribution payment, covering the period between the date coverage would otherwise stop and the end of the month preceding the date of the payment, within 45 days after the date the election to continue coverage was filed. Subsequent contributions are due on the first day of each month for which a qualified beneficiary continues coverage, and coverage will end if he or she fails to pay the contribution for any month within 30 days after the due date.
- (9) *No COBRA Coverage Pending Election or Payment.* A qualified beneficiary will not have COBRA coverage until he or she has elected the coverage and made the required contribution payment. No claims for health care incurred while coverage

is not in effect will be eligible for reimbursement. Once a qualified beneficiary makes the election and pays the contribution, coverage will be reinstated retroactively to the date he or she lost the coverage.

- (10) *Termination of COBRA Coverage.* The continuation coverage will terminate when the first of the following events occurs: (i) the end of the current Plan Year; (ii) the qualified beneficiary fails to pay the initial contribution within 45 days after your election, in which case he or she will be treated as not having elected to continue Medical FSA coverage; (iii) the qualified beneficiary fails to pay any other contribution within 30 days after it is due, in which case coverage will end as of the end of the last day of the month for which he or she made a timely contribution payment; (iv) after electing continuation coverage, the qualified beneficiary becomes entitled to any other group health plan that does not limit or exclude coverage because of a preexisting condition (coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage); and (v) the employer ceases to provide Medical FSA account benefits to any of its employees.
 - (11) *Keep the Plan Informed of Address Changes.* To protect Medical FSA COBRA continuation rights, qualified beneficiaries should keep the Plan Administrator informed of any address changes.
 - (12) *Keep Copies of Notices.* Qualified beneficiaries should also keep copies for their records of any notices sent to the Plan Administrator.
 - (13) *Plan Administrator Contact Information.* The address and telephone number for the Plan Administrator is listed in the *Plan Specifics*.
- (b) **HIPAA Privacy Rule Notice of Privacy Practices.** The Medical FSA component of the Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.
- (c) **Statement of ERISA Rights of Plan Participants.** As a participant in the Medical FSA under the Plan ("Plan"), 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:
- (1) *Receive Information About Your Plan and Benefits.*
 - (i) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan.
 - (ii) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan and copies of the latest annual report, if the plan is required to report, and updated summary plan description. This *Summary*, along with the sections of the *SelectAccount Flexible Benefit Plan*

and *Plan Specifics* that apply to the Medical FSA benefit, comprises the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

- (iii) 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.* Continue medical care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. Review this *Summary* for your Medical FSA continuation rights.
- (3) *Prudent Actions by Plan Fiduciaries.* In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of this 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 benefit provided under this plan or exercising your rights under ERISA.
- (4) *Appeals.* 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.
- (5) *Enforce Your Rights.* 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 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. 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.
- (6) *Assistance with Your Questions.* If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension

and Welfare Benefits 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.

- (d) **Company's Right to Terminate or Amend the Plan.** The Company reserves the right to amend or terminate the Plan at any time and without notice.
- (e) **No Guarantee of Employment.** Participation in this Plan is not a guarantee of employment.
- (f) **Plan Administrator's Discretion.** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.