

**ST. FRANCIS HEALTH SERVICES OF MORRIS, INC.**  
**SELECTACCOUNT FLEXIBLE BENEFIT PLAN**  
**PREMIUM REIMBURSEMENT ACCOUNT 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 Premium Reimbursement Account Benefit Option under the Plan. Through the Premium Reimbursement Account, you can pay Premiums for Other Health Insurance Coverage\* for yourself and eligible family members on a pre-tax basis from your salary or wages (your Employer only makes a contribution to your Premium Reimbursement Account if indicated on the *Plan Specifics*). This will generally result in a tax savings and increase your spendable income.

Refer to our *SelectAccount Flexible Spending Accounts Employee Brochure* for a tax savings example. You may also want to use the *Tax Savings Calculator* link available at [www.SelectAccount.com](http://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.

\* "Other Health Insurance Coverage" means individual coverage for you (the Eligible Employee) and your Dependents (including your spouse and children who qualify as your tax dependents). Your Premium for "Other Health Insurance Coverage" cannot be paid on a pre-tax basis through any other plan, and you cannot take a tax credit or deduction for your contributions. Your employer does not contribute to, sponsor, or administer the "Other Health Insurance Coverage". In this *Summary*, we will refer to "Other Health Insurance Coverage" as "your health insurance."

## 2. DETAILS REGARDING THE PREMIUM REIMBURSEMENT ACCOUNT BENEFIT

- (a) **Employer Contribution to the Premium Reimbursement Account.** Your Employer only makes a contribution to your Premium Reimbursement Account if indicated on the *Plan Specifics*
- (b) **Premiums Eligible for Reimbursement.** Only Premiums that you have paid for health plan coverage (described in Code section 106) that have not been paid or reimbursed through any other source may be reimbursed. An amount paid on a pre-tax basis through a spouse's employer's plan cannot be reimbursed.
- (c) **You must Request Reimbursement.** To receive reimbursement for Premiums, you must submit a completed claim request and independent third-party documentation of the expense (e.g., a copy of the insurer's premium invoice).
- (d) **Expenses Cannot be Reimbursed From Any Other Source, Including Tax Credits or Tax Deductions.** Duplicate reimbursements or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud, and you

personally will be responsible for any penalties. None of your Employer, the Plan Administrator or the Claims Administrator is responsible for monitoring your personal income tax or other financial affairs.

- (e) **The Amount in Your Premium Reimbursement Account May Not Match the Premiums Due for Your Health Insurance.** Your Premium Reimbursement Account is separate from your health insurance. The maximum amount that you are allowed to contribute is the Premium for your health insurance or, if less, the amount of your salary or wages. If you make a change to your health insurance, you will need to request that a corresponding election change be made to your Premium Reimbursement Account. Only Qualifying Election Changes (see below) will be permitted. An election change permitted under your health insurance may not be permitted under this *Summary* or vice versa. Your Premium Reimbursement Account benefit may be less or more than your actual Premium. If the Premium is more than the amount contributed to your Premium Reimbursement Account, you must pay the difference after-tax. If the Premium is less than the amount contributed to your Premium Reimbursement Account, you will forfeit the additional pre-tax payments made to your Account.
- (f) **Insurance Is Separate from this Plan.** This Plan only provides a way to pay Premiums for your health insurance. Your Employer has no responsibility for your eligibility for your health insurance or for the benefits it may provide.

### 3. **ELIGIBLE EMPLOYEES**

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

### 4. **DEPENDENTS**

- (a) Premiums for your health insurance for a family member may be reimbursed only if he or she qualifies as your Dependent.
- (b) “Dependent” means a person whom you can claim as a dependent on your federal income tax return (or whom you would be able to claim but for income limits that apply to income tax dependent status).
- (c) “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 after becoming an Eligible Employee and satisfying any Service Requirement. 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) **Premium Reimbursement Account Election.** You must indicate the amount you want to contribute, if any, to a Premium Reimbursement Account when you enroll. The Premium for your health insurance is the maximum you can elect to contribute to the Premium Reimbursement Account. When determining the amount that you want to contribute, keep in mind the amount that your Employer contributes, if any.

## 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”). The Election Change Event must affect eligibility for your health insurance, your eligibility to participate in the Premium Reimbursement Account, or the eligibility of Premiums for reimbursement from the Premium Reimbursement Account (e.g., your child no longer qualifies as your tax dependent).
- (b) **Examples.**
  - (1) If you get married or add a child to your family (through birth or adoption) and you add your new spouse or child to your health insurance, you can increase your Premium Reimbursement Account election.
  - (2) If you divorce, a child no longer qualifies as your tax dependent due to reaching a limiting age, or a family member dies, and you remove your spouse or your child from your health insurance, you can decrease your Premium Reimbursement Account election.
  - (3) If your spouse or a dependent starts or ends a job or increases or decreases his or her work hours and gains or loses eligibility for employer-sponsored health insurance and you remove or add your spouse or child to your health insurance as a result, you can make a corresponding increase or decrease your Premium Reimbursement Account election.

- (4) If a court order requires you or another person to provide health coverage for an eligible child and you add your child to your health insurance, a corresponding change can be made in your Premium Reimbursement Account election.
  - (5) If you, your spouse or your dependent gains or loses Medicare or Medicaid coverage and you add or remove coverage for that individual under your health insurance, a corresponding change can be made to your Premium Reimbursement Account election.
  - (6) You may change your Premium Reimbursement Account election in a manner consistent with changes made to your health insurance due to going on or returning from unpaid leave.
  - (7) If there is a change in the cost or coverage of your health insurance imposed by the health insurance company, a corresponding change can usually be made to your Premium Reimbursement Account election.
  - (8) If your spouse or dependent makes a mid-year election change in his or her employer's plan or if your spouse's or dependent's employer's plan has a different plan year or period of coverage than this Plan and you make a corresponding change to your individual health insurance, you may make a corresponding election change to your Premium Reimbursement Account (you cannot obtain reimbursement for employer-provided health insurance coverage through this Plan).
- (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 Premium Reimbursement Account for the Plan Year.
- (d) **Time Limit for Making Election Change.** To change your election, you must request an election change no 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.
- \*There are only two exceptions to the 30-day limit. The Children's Health Insurance Program Reauthorization Act (CHIPRA) permits you to request an election change no later than 60 days after the loss of your or your dependent's Medicaid or CHIP coverage because of loss of eligibility or within 60 days after the date you or your dependent becomes eligible for a premium assistance subsidy under Medicare or CHIP.
- (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**

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. Your leave must be approved by the Company.

Your Employer has no responsibility for your eligibility for your health insurance or for the benefits it may provide. You need to find out from your health insurer what impact, if any, a leave of absence has with respect to your health insurance.

You will be required to make your contributions for your Premium Reimbursement Account coverage to continue. If you do not make the required contribution when due (including any grace period), the Premiums for your health insurance will not be reimbursed. Premiums incurred during the period for which your coverage is retroactively terminated will not be reimbursed.

Contact the Plan Administrator for coverage payment options.

- (a) **Paid Leave of Absence.** Your Premium Reimbursement Account 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 Premium Reimbursement Account coverage during unpaid leave depends on the type of leave. If you do not elect to continue your Premium Reimbursement Account coverage at the beginning of leave, you will not be able to submit Premiums 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 Premium Reimbursement Account coverage. You must notify the Company's Human Resources Department of your decision.
    - (ii) If your Premium Reimbursement Account 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 Premiums you incurred during the leave for reimbursement. (Premiums you incur during the leave will be eligible for reimbursement only if you continued your Premium Reimbursement Account during 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 Premium Reimbursement Account 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 Premium Reimbursement Account 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 Premium Reimbursement Account coverage terminates as a result of your leave, you may elect to continue your coverage through COBRA. Premium Reimbursement Account 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 Premium Reimbursement Account 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 Premium Reimbursement Account benefits, you will not be eligible to participate in the Premium Reimbursement Account 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.** The amount available for reimbursement at any time will be limited to the balance in your Premium Reimbursement Account (your Payroll Contributions plus your Employer’s contributions (if any), less any reimbursements already made from the Account for that Plan Year).

(b) **Expense Must Be Eligible for Reimbursement Under this Plan.** Your health insurance must qualify as an “accident or health plan” within the meaning of Code section 106 for the Premium to be reimbursed from the Premium Reimbursement Account.

(c) **Expense Must Have Been Incurred During Your Period of Coverage for Plan Year.** You may only use your Premium Reimbursement Account to pay Premiums for your health insurance that you incurred during the Plan Year. Premiums for your health insurance incurred during one Plan Year cannot be reimbursed from contributions from another Plan Year. (A Premium will be considered to incurred on the Premium payment due date.)

(d) **Expense Cannot Be Reimbursed Out of Other Accounts.** An expense reimbursed through another Benefit Option cannot also be reimbursed through this Benefit Option.

(e) **Claim Submission Requirements Must be Satisfied.**

- (1) *Claims Must be Submitted to Claims Administrator.* Claims should be sent 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 a reimbursement for a Premium, you must submit a completed claim request and a Premium payment invoice from the insurance company showing: (i) period that the Premium covers; (ii) the Premium is for your health insurance; (iii) amount of the Premium; (iv) name of the health insurer; and (v) individuals covered by the health insurance. If claim information is incomplete, the claim may be denied.
- (4) *Claims Cannot Be Reimbursed from Any Other Source.* You cannot request reimbursement of a Premium that has been paid or reimbursed from any other source, such as a Premium paid by your spouse's employer or on a pre-tax basis through that employer's cafeteria plan. You will be required to certify that the Premium has not been reimbursed and will not be reimbursed from any other source.

(f) **Method of Reimbursement.** To the extent the Claims Administrator determines that a claim is properly payable under the Plan, you will be reimbursed directly for your Premium or, if directed by you, the Premium will be remitted to your insurance health plan or insurance carrier. Reimbursements will be issued as scheduled by the Claims Administrator. Claims must be submitted by noon at least two days prior to the scheduled reimbursement issuance date to be issued on the scheduled reimbursement issuance date. If the claim exceeds the amount in your Account, you will be reimbursed up to the amount available in your Account. A claim balance will be carried forward and will be paid when additional funds become available. You do not need to send in more than one claim for an Eligible Expense.

(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 the Plan; (ii) offsetting the amount from future reimbursement payments to you for eligible Premium 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.

(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 Claims Administrator. You must send a written request for an appeal review to the Claims 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.
- (4) *Notice of Continued Denial.* If the denial is upheld in whole or part, the Plan Administrator will send notification of the denial to the 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.

11. **FORFEITURE OF ACCOUNT BALANCE**

**According to federal tax law, amounts remaining in your Premium Reimbursement Account after the end of the Claims Submission Period following payment of Eligible Expenses incurred during the Plan Year and any Temporary Carry Over 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 Premium Reimbursement Account Election Worksheet to help you determine your contribution.

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

- (a) **When Participation Ends.** Your participation in the Premium Reimbursement Account will end as of the date of your termination of employment with the Company.
- (b) **Health Insurance Premiums Incurred After Termination.** Premiums for your health insurance incurred after the date of your termination from employment will not be eligible for reimbursement unless you elect to continue your participation in the Premium Reimbursement Account. 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) **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) **Your Health Insurance is Your Responsibility.** The Premium Reimbursement Account benefit only allows you to pay the Premiums for your health insurance from your salary or wages on a pre-tax basis. Your health insurance (which is purchased by you through the individual market) is your responsibility. Your health insurance is not sponsored by or administered by your Employer. The Company will be held harmless from any and all claims related to your health insurance for which the Premiums are paid through your Premium Reimbursement Account.
- (b) **COBRA Continuation of Premium Reimbursement Account Coverage.** You, your spouse or any of your dependents who lose coverage under the Premium Reimbursement Account as a result of a "qualifying event" are "qualified beneficiaries" and will be eligible to continue Premium Reimbursement Account coverage as indicated in this section.
- (1) *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 Premium Reimbursement Account; and (vi) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
- (2) *Maximum COBRA Coverage Period.* COBRA continuation coverage is a temporary continuation of Premium Reimbursement Account coverage. For each qualified beneficiary who elects COBRA continuation coverage, COBRA coverage will begin on the date of the qualifying event. When the qualifying event is the employee's death, Medicare entitlement, divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended. They are a disability

extension and a second qualifying event extension. Both are described below in the “You Must Notify the Plan Administrator of Certain Events” Section.

The maximum COBRA coverage periods described above will not be extended even though coverage under the Premium Reimbursement Account is continued unintentionally, resulting in a delay in termination of coverage, or the employer reduces or subsidizes, in whole or in part, the premium an individual is required to pay for COBRA coverage. The continuation coverage periods described above are maximum periods. Coverage will terminate before the end of the maximum period as described in the “Termination of COBRA Continuation” Section.

- (3) *You Must Notify 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 are required to notify the Plan Administrator of the events described below. 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*.

- (i) Qualifying events of divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child. Qualified beneficiaries must notify the Plan Administrator in writing within 60 days of the latest of: (1) the date of the event; (2) the date on which there is a loss of coverage due to the event; and (3) the date the qualified beneficiaries were furnished the summary plan description or this General Notice of Continuation Coverage Rights under COBRA informing them of their responsibility to notify the Plan of the event and the procedures for notifying the Plan. If qualified beneficiaries do not provide the required notice to the Plan Administrator within this time limit, they will lose the right to continuation coverage.

Qualified beneficiaries must send this notice to the Plan Administrator at the address stated above. The notice must include: (1) the name, address and Social Security Number of the employee; (2) the name, address and Social Security Number of each qualified beneficiary (*e.g.*, employee, spouse, dependent child); (3) a description of the qualifying event; (4) the date of the qualifying event; and (5) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

- (ii) Second Qualifying Event Extension of 18-month Period of Continuation Coverage. If qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months (including

the initial period of COBRA coverage), if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available if the employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Premium Reimbursement Account as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Premium Reimbursement Account had the first qualifying event not occurred.

To be eligible for an extension of coverage due to a second qualifying event, qualified beneficiaries must notify the Plan Administrator in writing of a second qualifying event and must do so within 60 days of the latest of: (1) the date of the second qualifying event; (2) the date on which there is a loss of coverage due to the second qualifying event; and (3) the date qualified beneficiaries were furnished the summary plan description or a General Notice of Continuation Coverage Rights under COBRA informing them of their responsibility to notify the Plan of the second qualifying event and the procedures for notifying the Plan. If qualified beneficiaries do not provide the required notice to the Plan Administrator within this time limit, they will lose the right to extend the continuation coverage.

Qualified beneficiaries must send the notice to the Plan Administrator at the address stated above. The notice must include: (1) your name, address and Social Security Number; (2) the name, address and Social Security Number of each qualified beneficiary; (3) a description of the second qualifying event; (4) the date that the second qualifying event occurred; and (5) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

- (iii) Social Security Administration Disability Determination. If a qualified beneficiary is determined by the Social Security Administration to be disabled and qualified beneficiaries notify the Plan Administrator in a timely fashion, qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To be eligible for the disability extension, qualified beneficiaries must notify the Plan Administrator of the Social Security Administration's determination in writing within 60 days after the latest of: (1) the date of the disability determination by the Social Security Administration; (2) the date on which a qualifying event occurs; (3) the date on which there is a loss coverage due to the qualifying event; or (4) the date qualified beneficiaries were furnished a summary plan description or a General Notice of Continuation Coverage Rights under COBRA informing them of their responsibility to notify the Plan of your eligibility for the disability extension and the procedures for notifying the Plan. Notwithstanding any other time limit in this paragraph, qualified beneficiaries must notify the Plan Administrator of the request for a disability

extension before the end of the 18-month period of COBRA continuation coverage. If qualified beneficiaries do not provide the required notice to the Plan Administrator within this time limit, qualified beneficiaries will lose the right to the disability extension.

Qualified beneficiaries must send the notice to the Plan Administrator at the address stated above. The notice must include: (1) your name, address and Social Security Number; (2) the name, address and Social Security Number of each qualified beneficiary; (3) a copy of the Social Security notice of disability determination; and (4) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

- (iv) End of Disability. If the disabled individual is determined by SSA to no longer be disabled, qualified beneficiaries must notify the Plan Administrator of that fact within 30 days after the later of the SSA's determination or the date on which they received the General Notice of COBRA Continuation Coverage Rights or the summary plan description notifying them of their responsibility to provide notice of end of disability to the Plan Administrator.

The notice must contain the following information: (1) your name, address and Social Security number; (2) the name, address and Social Security number of each qualified beneficiary; (3) a copy of the Social Security Administration notice of determination; and (4) a list of the Benefit Options under which the affected qualified beneficiaries are covered.

- (4) *Type of Coverage Available for Continuation.* A Qualified beneficiary may elect to continue the Premium Reimbursement Account coverage in effect immediately before the qualifying event. If, however, the coverage provided to similarly situated employees is eliminated and the employer continues to maintain other medical coverage, you will have the right to elect that other coverage.
- (5) *Who May Elect COBRA Coverage.* An employee can make the election for himself or herself, his or her spouse, and 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 the spouse make the election for a dependent child, the dependent may make the election for himself 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 Premium Reimbursement Account will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)
- (6) *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 Premium Reimbursement Account coverage. The election must be filed with the Plan Administrator at the address specified in the election form.

- (7) *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 beneficiaries 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.
- (8) *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 coverage.
- (9) *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 the qualified beneficiary will be treated as not having elected to continue Premium Reimbursement Account 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 the qualified beneficiary made a timely contribution payment; (iv) after electing continuation coverage, the qualified beneficiary become 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 Premium Reimbursement Account benefits to any of its employees.
- (10) *Keep the Plan Informed of Address Changes.* To protect Premium Reimbursement Account COBRA continuation rights, qualified beneficiaries should keep the Plan Administrator informed of any changes in the addresses of family members.
- (11) *Keep Copies of Notices.* Qualified beneficiaries should also keep a copies of any notices sent to the Plan Administrator.

- (12) *Plan Administrator Contact Information.* The address and telephone number for the Plan Administrator is listed in the *Plan Specifics*.
- (c) **HIPAA Privacy Rule Notice of Privacy Practices.** The Premium Reimbursement Account 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.
- (d) **Statement of ERISA Rights of Plan Participants.** As a participant in the Premium Reimbursement Account 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 Plan Document for the SelectAccount Flexible Benefit Plan that apply to the Premium Reimbursement Account 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 Premium Reimbursement Account 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.
- (e) **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.
- (f) **No Guarantee of Employment.** Participation in this Plan is not a guarantee of employment.
- (g) **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.