

**LINCOLN UNIVERSITY  
OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION**

**HEALTH CARE SPENDING ACCOUNT  
DEPENDENT CARE SPENDING ACCOUNT**

**SUMMARY PLAN DESCRIPTION**

**EFFECTIVE JULY 1, 2008**



**LINCOLN UNIVERSITY  
OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION**

**FLEXIBLE SPENDING ACCOUNT**

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## **SUMMARY PLAN DESCRIPTION INFORMATION**

### **Name of Plan**

Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account

### **Name, Address and telephone number of the Plan Administrator**

Lincoln University of the Commonwealth System of Higher Education  
1570 Old Baltimore Pike  
P.O. Box 179  
Lincoln University, PA 19352  
484-365-7594

### **Name and Address of the Person Designated as the Agent for Service of Legal Process**

Lincoln University of the Commonwealth System of Higher Education  
1570 Old Baltimore Pike  
P.O. Box 179  
Lincoln University, PA 19352  
484-365-7594  
Sharon Houston

### **Employer Identification Number (EIN)**

23-1352655

### **Plan Number**

502

### **Type of Plan**

Health Care Spending Account  
Dependent Care Spending Account

### **Initial Effective Date of the Plan**

Effective Date of this restated Plan Document is July 1, 2008.

### **Plan Year**

The twelve (12) month period for Lincoln University of the Commonwealth System of Higher Education beginning January 1 and ending December 31.



## ARTICLE I

### INTRODUCTION

This booklet explains the important provisions of the Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account (the “*Plan*”) as in effect as of July 1, 2008. In addition, it provides technical information concerning administration of the *Plan*.

The *Plan*, and all amendments to the *Plan*, together with other documents and records pertaining to the *Plan*, may be examined by *participants* and their legal representatives during regular business hours or by appointment at a mutually convenient time in the office of the *plan administrator*.

The *Plan* may be amended from time to time to comply with the requirements of applicable law or to reflect changes in your *employer’s* benefits program. If the *Plan* is amended, you will be advised of any important changes.

## ARTICLE II

### DEFINITIONS

Wherever used in the text of this plan document, the following italicized terms have the following meanings, unless a different meaning is clearly required by the context. Words in the singular form shall connote the plural form in all cases where they would so apply and vice versa.

#### 2.1 Annual Enrollment Period

Annual Enrollment Period means the period during which *employees* are permitted to make their elections in accordance with the Article entitled Elections for each *plan year*, and which shall be the period preceding the start of such *plan year* as shall be established by the *plan administrator*.

#### 2.2 Change in Family Status

A Change in family status means an event permissible under Section 125 of the *code* and the regulations promulgated thereunder as allowing a *participant* to change his or her election under that *Plan*. A change in family status means the following events:

- a) Marriage or divorce of the *employee*;
- b) Birth of the *employee's* child;
- c) Adoption of a child by the *employee*;
- d) Death of the *employee's* spouse or *dependent*;
- e) *Spouse's* commencement or termination of employment;
- f) *Employee's* or *spouse's* employment status changing from part-time to full-time or vice versa;
- g) *Employee* or *spouse* taking an unpaid leave of absence;
- h) Other events that are permissible under Section 125 of the *code*, and the regulations promulgated thereunder, and are approved by the *plan administrator*; and
- i) Loss of health coverage under another health plan due to exhaustion of COBRA coverage or cessation of eligibility for the other coverage.

### 2.3 **Code**

Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or any subdivision of a section of the *code* shall include a reference to any comparable or succeeding provision of any legislation which amends, supplements, or replaces such section or subdivision.

### 2.4 **Compensation**

Compensation means the regular pay of an *employee* as reported on Form W-2.

### 2.5 **Compensation Reduction Agreement**

*Compensation reduction agreement* means an agreement whereby an *employee* authorizes the *employer* to reduce his or her *compensation* by the amount equal to the *participant's* share of the cost of each optional benefit elected by the *employee* under this *Plan*.

### 2.6 **Effective Date**

Effective Date of this restated Plan Document is July 1, 2008.

### 2.7 **Employee**

Employee means an individual who is employed by the *employer* and who is regularly scheduled to work at least twenty (20) hours per week, except as otherwise stated elsewhere in this *Plan*.

For individuals employed at a Massachusetts location: If your employer employs 11 or more full-time-equivalent employees, Employee means an individual who is employed by the Employer and who is regularly scheduled to work at least 64 hours per month. This Plan will comply with the requirement of all the terms of 956 CMR 4.00 of the Massachusetts Connector established under M.G.L. c. 176Q.

### 2.8 **Employer**

Employer means Lincoln University of the Commonwealth System of Higher Education.

### 2.9 **Grace Period**

The Grace Period extends the deadline for incurring and reimbursement of health and dependent care expenses up to 2 months and 15 days after the end of the *plan year*. The effect of the Grace Period is that the *participant* may have as long as 14 months and 15 days to use the benefits or contributions for a *plan year*.

2.10 **Highly Compensated Employee**

Highly compensated employee means any employee who meets the definition of highly compensated individual in Section 125(e) of the *code*.

2.11 **Key Employee**

Key employee means any *employee* who meets the definition of key employee in Section 416(i)(1) of the *code*.

2.12 **Participant**

Participant means any *employee* who has elected to participate in the *Plan* in accordance with the provisions of the Article entitled Elections and whose participation has not terminated in accordance with Section 3.3.

2.13 **Plan**

Plan means the Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account, which is set forth in this document.

2.14 **Plan Administrator**

Plan Administrator means the *employer* or such other person, committee, or entity as may be appointed from time to time by the *employer* pursuant to Article VIII.

2.15 **Plan Year**

The twelve (12) month period for Lincoln University of the Commonwealth System of Higher Education beginning January 1 and ending December 31.

2.16 **Special Enrollee**

*Special enrollee* means an *employee* or *dependent* who is entitled to and requests special enrollment:

- a) Within thirty (30) days of losing other health coverage either because his or her COBRA coverage is exhausted, he or she ceases to be eligible for other coverage, or *employer* contributions are terminated, or
- b) For a newly acquired dependent, within thirty (30) days of the marriage, birth, adoption or placement for adoption.

**ARTICLE III**  
**PARTICIPATION**

**3.1 Eligibility to Participate**

Each *employee* of the *employer* is eligible to participate in the *Plan*.

**3.2 Commencement of Participation**

An *employee* becomes a *participant* in the *Plan* by filing an election form with the *plan administrator* in accordance with the terms of the Article entitled *Elections*. The participation of any such *employee* shall commence according to the following schedule:

- a) **Initial Plan Year Of The Restated Plan Document:** Each *employee* who is employed by the *employer* before the first day of the *plan year* beginning July 1, 2008 and who files an election form during the 2008 *annual enrollment period* or who is deemed to have filed pursuant to the terms of Section 4.2 of Article IV shall become a *participant* on the *effective date*.
- b) **New and Returning Former Employees:** Each *employee* who is first employed by the *employer* on or after the *effective date* and who files an election form with the *plan administrator* during the 30-day period beginning on the date such employment begins shall become a *participant* in the *Plan* on the first day of the month following the date of hire or as designated by the relevant Collective Bargaining Agreement.

**3.3 Termination of Participation**

A *participant's* participation in the *plan* shall terminate as of the earliest of:

- a) The date such *participant* ceases to be an *employee*; or
- b) The date on which the *plan* terminates.

Although a *participant's* participation under this *plan* terminates on the earlier of the above dates, coverage or benefits under one or more of the benefit options available under this *Plan* may continue if and to the extent provided elsewhere under this *Plan*.

### 3.4 **Reinstatement of Former Participant**

If the *employee* is reemployed during the same *plan year* that he or she separated from the service of the *employer*, such *employee* shall not be allowed to make a new election under this *plan*. Rather, the *employee* shall have coverage reinstated under the benefits option(s) selected under this *Plan* identical to those which were in effect prior to the date that he or she separated from the service of the *employer*.

An *employee* who is reemployed in a *plan year* following the *plan year* in which participation in this *Plan* has previously terminated under Section 3.3(a) may again become a *participant* by filing an election form with the *plan administrator* during the thirty (30) day period following the date of the new employment.

## ARTICLE IV

### ELECTIONS

#### 4.1 Election Procedure

##### a) Annual Enrollment

- i) At the beginning of each *annual enrollment period*, the *plan administrator* shall provide each *employee* one or more written election forms, which shall include one or more *compensation reduction agreements*. Each *employee* who desires one or more of the benefit options available under this *Plan* during the next succeeding *plan year* shall so specify on the election form(s). Each *employee* who does not desire any of such benefit options shall specify on the election form(s) that his or her full *compensation* shall be paid in cash.
- ii) An amount equal to the required reduction will be contributed by the *employer* to the *Plan* under the appropriate benefit option(s).
- iii) Each election form and *compensation reduction agreement* must be completed and returned to the *plan administrator* on or before the last day of the *annual enrollment period*, which date shall be no later than the day prior to the first day of the *plan year* for which the *participant's compensation reduction agreement*, if any, will apply.

##### b) Change in Family Status

- i) When the *plan administrator* is notified by an *employee* that he or she has experienced a *change in family status* and, as a result, wishes to change the election for that *plan year* pursuant to the terms of Section 4.3, the *plan administrator* shall provide the *employee* with one or more written election forms, which shall include one or more *compensation reduction agreements*. Such *employee* shall, pursuant to the terms of the option under which the benefits are to be provided and in accordance with the policies established by the *plan administrator*, specify on the election form(s) which prior elections are to be revoked and which benefits are being elected for the balance of the *plan year*.
- ii) An amount equal to the new reduction will be contributed by the *employer* to the *Plan* under the appropriate benefit option(s).

iii) Each new election form and *compensation reduction agreement* must be completed and returned to the *plan administrator* on or before such date as the *plan administrator* shall specify, which date shall be no later than the day prior to the first day of the first pay period for which the *participant's* new *compensation reduction agreement*, if any, will apply.

c) **New Employees**

As soon as practicable after a new *employee* is employed, the *plan administrator* shall provide the written election forms to such *employee*. If the *employee* desires one or more of the benefit options available under this *Plan* for the balance of the then-current *plan year*, the *employee* shall so specify on the election form and shall agree to a reduction in *compensation* as provided in Section 4.1. Each *employee* who does not desire any of such benefit options shall specify on the election form that his or her full *compensation* shall be paid in cash. The election form and *compensation reduction agreement* must be completed and returned to the *plan administrator* on or before such date as the *plan administrator* shall specify, which date shall be no later than the day prior to the first day of the first pay period for which the *employee's* *compensation reduction agreement*, if any, will apply.

d) **Special Enrollees**

A *special enrollee* who requests enrollment in the *Plan* pursuant to Section 2.15 shall receive an election form from the *plan administrator* and shall specify on the election form(s) which prior elections are to be revoked and which benefits are being elected for the balance of the *plan year*. An amount equal to the new reduction will be contributed by the *employer* to the *Plan* under the appropriate benefit option(s).

4.2 **Deemed Election**

An *employee* who fails to return a completed election form to the *plan administrator* on or before the specified due date for the initial *plan year* or the thirty (30) day enrollment period for the *plan year* during which the *employee* was first employed shall be deemed to have elected no coverage under any of the benefit options available under this *Plan*.

An *employee* who is a *participant* at the time the election form for any *plan year* is due and who fails to return the completed election form to the *plan administrator* on or before its specified due date shall be deemed to have elected no coverage under any of the benefit options available under this *Plan*.

#### 4.3 **Changes in Elections**

Elections made under the *Plan* shall be irrevocable by the *participant* during the *plan year*, except following the occurrence of a *change in family status*. If a *participant* experiences a *change in family status*, the *participant* may revoke the applicable benefit election for the balance of the *plan year* and file a new election in accordance with the policies established by the *plan administrator*. The new election shall be filed with the *plan administrator* in accordance with the provisions of Section 4.1.

#### 4.4 **Automatic Termination of Election**

Elections made under this *Plan* shall automatically terminate on the date on which the *participant* ceases to be a *participant* in the *Plan* as determined in Section 3.3, although coverage or benefits under the benefit option(s) may continue if and to the extent provided elsewhere under this *Plan*.

## ARTICLE V

### BENEFITS

#### 5.1 Form of Benefits

Under this *Plan*, a *participant* may elect to receive his or her full *compensation* for any *plan year* in cash or to have a portion of such *compensation* applied toward the cost of one or more of the benefit options available under this *Plan*.

#### 5.2 Benefit Options

A *participant* may elect in accordance with Section 4.1 to receive either cash or one or more of the benefit options available under this *Plan*:

- a) Health Care Spending Account.
- b) Dependent Care Spending Account.

#### 5.3 Description of Benefits Other Than Cash

The terms and conditions of coverage, the requirements for participation, and the types and amounts of benefits available under Sections 5.2 (b) and 5.2 (c) shall be as set forth in the following articles of this *Plan*:

- a) Health Care Spending Account – Article VI; and
- b) Dependent Care Spending Account – Article VII.

#### 5.4 Limitations on Contributions

The maximum amount by which a *participant* may reduce his or her *compensation* under this *Plan* shall not exceed the sum of the greatest *participant* contributions required by the *employer*-sponsored health benefits plan(s), plus the maximum contributions allowed under the Health Care Spending Account and Dependent Care Spending Account provisions of this *Plan*.

## ARTICLE VI

### HEALTH CARE SPENDING ACCOUNT

#### 6.1 Purpose

This portion of the *Plan* is established and shall be maintained to provide *employees* with the opportunity to receive reimbursement for *qualifying health care expenses*. The terms of this Article shall be interpreted in a manner consistent with the requirements of Section 105 of the *code*.

#### 6.2 Definitions

For purposes of this Article, the terms listed below shall be defined as follows:

a) **COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

b) **Code**

Code means the Internal Revenue Code of 1986, as amended.

c) **Continuation Coverage**

Continuation Coverage means the *Plan* coverage elected by a Qualified Beneficiary under COBRA.

d) **Covered *Employee***

Covered *employee* has the same meaning as that term is defined in COBRA and the regulations thereunder.

e) **Dependent**

Dependent means an individual who meets the definition of dependent in Section 152 of the *code*.

f) **Highly Compensated Employee**

Highly compensated employee means any *employee* who meets the definition of highly compensated individual in Section 105(h) of the *code*.

**g) Qualifying Health Care Expenses**

Qualifying Health Care Expenses means an expense incurred during a *plan year* by a *participant*, a *participant's* Spouse or by the *dependents* of such *participant*, for medical care as defined in Section 213 of the *code*, but only to the extent that the *participant* or other person incurring the expense is not reimbursed for the expense through coverage under another plan or otherwise. Expenses are treated as having been incurred when the *participant* is provided with the medical care that gives rise to the medical expenses, and not when the *participant* is formally billed or charged for, or pays for the medical care. Expenses for premiums paid for health coverage under any plan shall not be considered Qualifying Health Care Expenses.

**h) Qualified Beneficiary**

Qualified Beneficiary means:

- i) A Covered *employee* whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the *Plan*;
- ii) A covered spouse or dependent who becomes eligible for coverage under the *Plan* due to a Qualifying Event, as defined below; or
- iii) A newborn or newly adopted child of a Covered *employee* who is continuing coverage under COBRA.

**i) Qualifying Event**

Qualifying Event means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

- i) Termination of a Covered *employee's* employment (other than for gross misconduct) or reduction in his hours of employment;
- ii) The death of the Covered *employee*;
- iii) The divorce or legal separation of the Covered *employee* from his spouse;
- iv) A child ceasing to be eligible as a dependent child under the terms of the Group Health Plan; or
- v) Your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.

j) **Totally Disabled**

Totally Disabled or Total Disability means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

6.3 **Form of Benefits**

The benefits of this Article shall be in the form of reimbursements to *participants* for *qualifying health care expenses* incurred during the *plan year*, and shall be paid from the general assets of the *employer*.

6.4 **Maximum Contribution**

Except as provided below, the maximum contribution that a Participant may authorize as Compensation reduction for the Plan Year shall not exceed \$3,000.

6.5 **Minimum Contribution**

Except as provided below, the minimum contribution that a Participant may authorize as Compensation reduction for the Plan Year shall not be less than \$100.

6.6 **Reimbursement Claims**

a) Claims for reimbursement must be in writing, in such form as prescribed by the *plan administrator* and shall include the following information:

- i) A statement from an independent third party stating that Qualifying Health Care Expenses were incurred and the amount of such expenses;
- ii) The individual's name and age on whose behalf *qualifying health care expenses* were incurred and the individual's relationship to the *participant*;
- iii) The dates on which *qualifying health care expenses* were incurred; and
- iv) A statement from the *participant* that the *qualifying health care expenses* have not been reimbursed, or are not reimbursable, under any other health care plan.

The *qualifying health care expenses* will notify the *participant* if additional information is required to process the claim.

b) You may submit a claim at any time during the period that begins when the expense is incurred, and ends ninety (90) days after the close of the *grace period*.

c) Claims incurred during the *grace period* will be applied to the previous *plan year's* account fund. Once exhausted, claims will be applied to the new *plan year's* fund.

#### 6.7 **Maximum Reimbursement**

The maximum reimbursement payable to a *participant* at any time for *qualifying health care expenses* is the *participant's* authorized *compensation* reduction for the *plan year*, as indicated in the *compensation reduction agreement*, less any reimbursements previously paid to the *participant* for the same *plan year*.

#### 6.8 **Overpayments**

If, for any reason, a reimbursement is erroneously made under this Article, the *participant* shall be responsible for refunding the amount to this *Plan*. The refund shall be made pursuant to the method established by the *plan administrator*.

#### 6.9 **Forfeitures**

A *participant's* contributions for any *plan year* shall be used only to reimburse the *participant* for *qualifying health care expenses* incurred during such *plan year* and only if the *participant* applies for such reimbursement in accordance with the procedure established by the *plan administrator*.

In the event that the *participant's* contributions exceed the amount of reimbursements for *qualifying health care expenses* incurred during the *plan year* and submitted for reimbursement by the end of the time period specified, the excess amount shall not be refunded to the *participant* nor shall such amounts be carried over to reimburse the *qualifying health care expenses* for *qualifying health care expenses* incurred during a subsequent *plan year*. Such amounts shall be forfeited by the *participant*. Subject to applicable law and regulation, any forfeitures shall revert to the *employer*.

#### 6.10 **Facility of Payment**

When any *participant* entitled to benefits under this Article is under legal disability or, in the *plan administrator's* opinion, is in any way incapacitated so as to be unable to manage affairs, or is deceased, the *plan administrator* may cause such *participant's* benefits to be paid to such *Participant's* legal representative. Such payment of benefits shall completely discharge the liability of the *plan administrator* or the *employer* for such benefits.

#### 6.11 **Claims Procedures**

a) All claims for reimbursement and all questions relating to such claims shall be submitted to the *plan administrator*.

- b) If a claim is wholly or partially denied, the *plan administrator* shall furnish you with a written explanation of the Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after the claim is filed. This thirty (30) day period may be extended once by the *plan administrator* for up to fifteen (15) days provided:
  - i) The *plan administrator* determines that an extension is necessary due to circumstances beyond the *Plan's* control; and
  - ii) The *plan administrator* notifies the claimant before the end of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the *Plan* intends to render a decision on the claim.
- c) A written explanation of a claim denial will include the following information:
  - i) The specific reason(s) for the denial of the claim;
  - ii) Reference to the *Plan* provision(s) on which the denial is based;
  - iii) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
  - iv) A description of the *Plan's* appeal procedure and applicable time limits to such procedures;
  - v) A statement that you, your attorney, or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine pertinent *Plan* documents and records, and submit written comments on the issue(s); and
  - vi) A statement regarding the *participant's* right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

## 6.12 How To Appeal An Adverse Benefit Determination

- a) The *plan administrator* shall review the information and comments submitted by the *participant* or the *participant's* duly authorized representative. The *plan administrator* may hold a hearing of all parties involved, if the *plan administrator* deems such hearing to be necessary. The *plan administrator* shall furnish you with a written claim appeal determination within a reasonable period of time, but not later than sixty (60) days after the appeal is filed.

- b) A written explanation of a claim appeal determination will include the following information:
  - i) The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;
  - ii) Reference to *Plan* provisions and records on which the decision is based;
  - iii) A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and
  - iv) A statement regarding the *participant's* right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.
- c) Limitations
  - i) The timeframes for review of Adverse Benefit Determinations will be tolled (i.e., suspended) from the date on which notice was sent to the claimant until the date that the claimant responds to the request for information.
  - ii) No action at law or in equity can be brought to recover under this *Plan* prior to the expiration of the first one hundred and eighty (180) days after the claim has been filed with the *plan administrator*.
  - iii) No action at law or in equity can be brought to recover under this *Plan* after the expiration of two years after the claim has been filed with the *plan administrator*.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

Benefit Concepts, Inc.  
P. O. Box 60608  
King of Prussia, PA 19406-0608

### 6.13 **Nondiscrimination**

This *Plan* is intended not to discriminate in favor of *highly compensated employees* as to eligibility to participate as required by Section 105(h) of the *code*. If, in the judgment of the *plan administrator*, the *Plan* so discriminates, the *plan administrator* shall impose a pro rata reduction on the benefit elections of all *highly compensated employees*, as appropriate, sufficient to ensure compliance with such requirements or limitations.

#### 6.14 **Reliance by *Plan Administrator***

In administering the *Plan*, the *Plan Administrator* shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by or in accordance with the instructions of accountants, counsels, or other experts employed or engaged by the *plan administrator*

#### 6.15 **No Guarantee of Tax Consequences**

Neither the *plan administrator* nor the *employer* makes any commitment or guarantee that any amounts paid to or for the benefit of a *participant* under this *Plan* will be excludable from the *participant's* gross income for federal, state, or local income tax purposes or that any other federal, state, or local tax treatment will apply to or be available to any *participant*. It shall be the obligation of each *participant* to determine whether such payments are excludable from his or her gross income for federal, state, or local income tax purpose and to notify the *employer* if the *participant* has reason to believe that any such payment is not so excludable.

#### 6.16 **COBRA Continuation of Benefits**

a) If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the 60-day period beginning on the later of:

- i) The date of the Qualifying Event; or
- ii) The date he was notified of his right to continue coverage.

If you are considered an eligible worker, in accordance with the Trade Adjustment Assistance Reform Act of 2002 (TAA), you may be entitled to elect COBRA Continuation Coverage during the 60-day period beginning on the first day of the month in which you begin receiving Trade Adjustment Assistance provided that the election is made within the six (6) month period immediately following the date of the TAA-related loss of coverage.

#### b) **Notification of Qualifying Event**

If the Qualifying Event is divorce, legal separation or a dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within 60 days of the event in order for coverage to continue. You must report the Qualifying Event to the *plan administrator* in writing. The statement must include:

- i) Your name;
- ii) Your identification number;
- iii) The dependent's name;
- iv) The dependent's last known address;
- v) The date of the Qualifying Event; and
- vi) A description of the event.

In the case of a request for extension of the COBRA period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

**c) Length of Continuation Coverage**

- i) A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered *employee* may continue coverage under the *Plan* for up to 18 months from the date of the Qualifying Event.
- ii) A Qualified Beneficiary who loses coverage due to the Covered *employee's* death, divorce, or legal separation, and dependent children who have become ineligible for coverage may continue coverage under the *Plan* for up to 36 months from the date of the Qualifying Event.

**d) Total Disability**

- i) In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within 60 days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for dependents who were covered under the Continuation Coverage) for a total of 29 months as long as the Qualified Beneficiary notifies the *employer*:

- 1) Prior to the end of 18 months of Continuation Coverage that he has been determined by the Social Security Administration to be disabled within 60 days of the date of the Qualifying Event; and
  - 2) Within 60 days of the determination of Total Disability under the Act.
- ii) The *employer* will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond 18 months pursuant to this section.
  - iii) If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:
    - 1) The Qualified Beneficiary shall notify the *employer* of this determination within 30 days; and
    - 2) Continuation Coverage shall terminate the last day of the month following 30 days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.
- e) **Termination of Continuation Coverage**

Continuation Coverage will automatically end earlier than the applicable 18, 29, or 36-month period for a Qualified Beneficiary if:

- i) The required monthly contribution for coverage is not received by the Company within 30 days following the date it is due;
  - ii) The Qualified Beneficiary becomes covered under any other Flexible Spending Account as an *employee* or otherwise;
  - iii) For Totally Disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such beneficiary is no longer Totally Disabled;
  - iv) The Qualified Beneficiary becomes entitled to Medicare benefits; or
  - v) The Company ceases to offer any Flexible Spending Accounts.
- f) **Multiple Qualifying Events**

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18- or 29- month period, the Qualified Beneficiary may elect,

in accordance with the section entitled “Right To Elect Continuation Coverage”, to continue coverage under the Group Health Plan for up to 36 months from the date of the first Qualifying Event.

**g) Continuation Coverage**

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Flexible Spending Account offered to similarly situated Covered *employees* and their dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of dependent under the Group Health Plan.

**h) Carryover of Plan Maximums**

If Continuation Coverage under this *Plan* is elected by a Qualified Beneficiary under COBRA, expenses already credited to maximum payments under the *Plan* will be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which *Plan* maximums have been reached.

**i) Payment of Premium**

- i) The Flexible Spending Account will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.
  - 1) The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.
  - 2) For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled “Total Disability” of this provision, the *Plan* may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage months 19-29.
  - 3) Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.
- ii) If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within 45 days of the date of election.

- iii) Without further notice from the Company, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage", subsection A. This 30-day *grace period* does not apply to the first contribution required under subsection B.
- iv) No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

## ARTICLE VII

### DEPENDENT CARE SPENDING ACCOUNT

#### 7.1 Purpose

This portion of the *Plan* is established and shall be maintained to provide *employees* with the opportunity to receive reimbursement for Qualifying Dependent Care Expenses. The terms of this Article shall be interpreted in a manner consistent with the requirements of Section 129 of the *code*.

#### 7.2 Definitions

For purposes of this Article, the terms listed below shall be defined as follows:

##### a) **Dependent**

Dependent means an individual who meets the definition of dependent in Section 152 of the *code*.

##### b) **Dependent Care Assistance**

Dependent Care Assistance means the payment or reimbursement of Qualifying Dependent Care Expenses.

##### c) **Earned Income**

Earned Income means all income derived from wages, salaries, bonuses, commissions, and other *employee compensation* and net earnings derived from self-employment [within the meaning of *code* Section 1402(a)], but such term does not include any amounts:

- i) Received under this Article or any other dependent care assistance program under *code* Section 129; or
- ii) Received as a pension or annuity.

A *participant's* spouse who is a full-time student (at least five months during the *plan year*) or physically or mentally incapable of caring for himself shall be deemed to have Earned Income of not less than:

- i) two hundred dollars if there is one Dependent for whom the *participant* incurs Covered Expenses, or

- ii) four hundred dollars if there is more than one Dependent for whom the *participant* incurs Covered Expenses for each month that such spouse is a full-time student or physically or mentally incapable of caring for himself.
- d) **Highly Compensated Employee**

Highly Compensated employee means any *employee* who meets the definition of highly compensated individual in Section 414(q) of the *code*.
- e) **Principal Shareholder/Owner**

Principal Shareholder/Owner means an individual who meets the definition of such term in Section 129(d)(4) of the *code*.
- f) **Qualifying Dependent Care Expenses**

Qualifying Dependent Care Expenses means employment-related expenses as defined in Section 21(b)(2) of the *code*.
- g) **Qualifying Individual**

Qualifying Individual means an individual who meets the definition of qualifying individual in Section 21(b)(1) of the *code*.

### 7.3 **Form of Benefits**

The benefits of this Article shall be in the form of reimbursements to *participants* for qualifying dependent care expenses incurred during the *plan year* for the care of a Qualifying Individual, and shall be paid from the general assets of the *employer*.

### 7.4 **Maximum Contribution**

Except as provided below, the maximum contribution that a *participant* may authorize as *compensation* reduction for the *plan year* shall not exceed \$5,000, or \$2,500 for married *participants* filing separate tax returns.

### 7.5 **Reimbursement Claims**

- a) Claims for reimbursement must be in writing, in such form as prescribed by the *plan administrator* and shall include the following information:
  - i) A statement from an independent third party stating that Qualifying Dependent Care Expenses were incurred and the amount of such expenses;

- ii) The individual's name and age on whose behalf Qualifying Dependent Care Expenses were incurred and the individual's relationship to the *participant*;
- iii) The dates on which Qualifying Dependent Care Expenses were incurred; and
- iv) A statement from the *participant* that the Qualifying Dependent Care Expenses have not been reimbursed, or are not reimbursable, under any other health care plan.

The *plan administrator* will notify the *participant* if additional information is required to process the claim.

- b) You may submit a claim at any time during the period that begins when the expense is incurred, and ends ninety (90) days after the close of the *grace period*.
- c) Claims incurred during the *grace period* will be applied to the previous *plan year's* account fund. Once exhausted, claims will be applied to the new *plan year's* fund.

#### 7.6 **Maximum Reimbursement**

The maximum reimbursement payable to a *participant* at any time for *qualifying dependent care expenses* is the amount of contributions made to the *Plan* pursuant to this Article for that *plan year*, less any reimbursements previously paid to the *participant* for the same *plan year*.

#### 7.7 **Expense Accumulation**

A *qualifying dependent care expense* that is unable to be reimbursed because of insufficient contributions to the *Plan* shall be accumulated by the *participant* and reimbursed as future contributions are made into the *Plan* during the balance of the *plan year*.

#### 7.8 **Unreimbursed Contributions**

If a *participant* has unreimbursed contributions remaining in the *plan* at the time participation would otherwise terminate pursuant to Section 3.3, that *participant* shall be eligible to submit for reimbursement *qualifying dependent care expense* which are incurred before the end of the *plan year*.

#### 7.9 **Overpayments**

If, for any reason, a reimbursement is erroneously made under this Article, the *participant* shall be responsible for refunding the amount to this *Plan*. The refund shall be made pursuant to the method established by the *plan administrator*.

## 7.10 Forfeitures

A *participant's* contributions for any *plan year* shall be used only to reimburse the *participant* for *participant's* incurred during such *plan year* and only if the *participant* applies for such reimbursement in accordance with the procedure established by the *plan administrator*.

In the event that the *participant's* contributions exceed the amount of reimbursements for Qualifying Dependent Care Expenses incurred during the *plan year* and submitted for reimbursement by the end of the time period specified, the excess amount shall not be refunded to the *participant* nor shall such amounts be carried over to reimburse the *participant* for Qualifying Dependent Care Expenses incurred during a subsequent *plan year*. Such amounts shall be forfeited by the participant. Subject to applicable law and regulation, any forfeitures shall revert to the *employer*.

## 7.11 Facility of Payment

When any participant entitled to benefits under the *Plan* is under legal disability or, in the *plan administrator's* opinion, is in any way incapacitated so as to be unable to manage affairs, or is deceased, the *plan administrator* may cause such *participant's* benefits to be paid to such *participant's* legal representative. Such payment of benefits shall completely discharge the liability of the *plan administrator* or the *employer* for such benefits.

## 7.12 General Limitations and Exclusions

The following are general limitations and exclusions for which no benefits are payable under the provisions of this *Plan* for any *plan year*:

- a) Expenses incurred by a *participant* which are paid to either (1) a *participant's* child who is under the age of 19 or (2) a person for whom the *participant* or his spouse can claim a personal exemption dependent deduction under the *code*.
- b) Expenses incurred by a *participant* who is unmarried at the close of the tax year which are in excess of the lesser of (1) the *participant's* Earned Income or (2) \$5,000.
- c) Expenses incurred by a *participant* which are in excess of the lesser of
  - i) his Earned Income,
  - ii) the spouse's Earned Income, or
  - iii) \$5,000, if the *participant* is married at the close of the tax year and filing a joint federal income tax return.

- d) Expenses incurred by a *participant* which are in excess of the lesser of
  - i) his Earned Income,
  - ii) the spouse's Earned Income, or
  - iii) \$2,500, if the *participant* is married at the close of the tax year and filing a separate federal income tax return.
- e) Expenses incurred by a *participant* which are paid to a Dependent Care Center which does not meet the definition as defined in Section 21(b)(2) of the *code* and which does not comply with all applicable state and local laws and regulations.
- f) Expenses incurred by a *participant* which are not necessary for such person to be gainfully employed.
- g) Expenses incurred by a *participant* for a Dependent who does not meet the definition of a Dependent as set forth in Section 7.2(a).
- h) Expenses incurred by a *participant* that do not meet the definition of Qualifying Dependent Care Expenses as set forth in Section 7.2(f).
- i) Expenses incurred by a *participant* for camp where the Dependent stays overnight.
- j) Expenses incurred by a *participant* before the beginning of the *plan year* or after the end of the *plan year*.
- k) Expenses incurred by a *participant* before the *participant* becomes covered under this *Plan*.
- l) Expenses incurred by a *participant* after the date coverage under this *Plan* is terminated.

### 7.13 **Claims Procedures**

- a) All claims for reimbursement and all questions relating to such claims shall be submitted to the *plan administrator*.
- b) If a claim is wholly or partially denied, the *plan administrator* shall furnish you with a written explanation of the Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after the claim is filed. This thirty (30) day period may be extended once by the *plan administrator* for up to fifteen (15) days provided:

- i) The *plan administrator* determines that an extension is necessary due to circumstances beyond the *Plan's* control; and
  - ii) The *plan administrator* notifies the claimant before the end of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the *plan* intends to render a decision on the claim.
- c) A written explanation of a claim denial will include the following information:
- i) The specific reason(s) for the denial of the claim;
  - ii) Reference to the *Plan* provision(s) on which the denial is based;
  - iii) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
  - iv) A description of the *Plan's* appeal procedure and applicable time limits to such procedures;
  - v) A statement that you, your attorney, or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine pertinent Plan documents and records, and submit written comments on the issue(s); and
  - vi) A statement regarding the *participant's* right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

#### 7.14 **How To Appeal An Adverse Benefit Determination**

- a) The *plan administrator* shall review the information and comments submitted by the *participant* or the *participant's* duly authorized representative. The *plan administrator* may hold a hearing of all parties involved, if the *plan administrator* deems such hearing to be necessary. The *plan administrator* shall furnish you with a written claim appeal determination within a reasonable period of time, but not later than sixty (60) days after the appeal is filed.
- b) A written explanation of a claim appeal determination will include the following information:
  - i) The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;
  - ii) Reference to *Plan* provisions and records on which the decision is based;

- 1) A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and
  - 2) A statement regarding the *participant's* right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.
- c) Limitations
- i) The timeframes for review of Adverse Benefit Determinations will be tolled (i.e., suspended) from the date on which notice was sent to the claimant until the date that the claimant responds to the request for information.
  - ii) No action at law or in equity can be brought to recover under this *Plan* prior to the expiration of the first one hundred and eighty (180) days after the claim has been filed with the *plan administrator*.
  - iii) No action at law or in equity can be brought to recover under this *Plan* after the expiration of two years after the claim has been filed with the *plan administrator*.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

Benefit Concepts, Inc.  
P. O. Box 60608  
King of Prussia, PA 19406-0608

#### 7.15 **Nondiscrimination**

This *Plan* is intended not to discriminate in favor of *highly compensated employees* as to eligibility to participate as required by Section 129(d)(3) of the *code* or as to contributions and benefits, as required by Sections 129(d)(2) and 129(d)(8) of the *code*; or in favor of Principal Shareholders/Owners as to benefits received under the *Plan* as required by Section 129(d)(4) of the *code*. If, in the judgment of the *plan administrator*, the *Plan* so discriminates, the *plan administrator* shall impose a pro rata reduction on the benefit elections of all *highly compensated employees* or Principal Shareholders/Owners, as appropriate, sufficient to ensure compliance with such requirements or limitations.

#### 7.16 **Reliance by Plan Administrator**

In administering the *Plan*, the *plan administrator* shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by or in accordance with the instructions of accountants, counsels, or other experts employed or engaged by the *plan administrator*.

#### 7.17 **Annual Participant Statement**

On or before January 31 of each year, the *plan administrator* shall furnish to each *participant* a written statement showing the amount of Dependent Care Assistance provided to the *participant* during the prior calendar year. The *plan administrator* may satisfy this requirement by reporting the amount on Form W-2.

#### 7.18 **No Guarantee of Tax Consequences**

Neither the *plan administrator* nor the *employer* makes any commitment or guarantee that any amounts paid to or for the benefit of a *participant* under this *Plan* will be excludable from the *participant's* gross income for federal, state, or local income tax purposes or that any other federal, state, or local tax treatment will apply to or be available to any *participant*. It shall be the obligation of each *participant* to determine whether such payments are excludable from his or her gross income for federal, state, or local income tax purpose and to notify the *employer* if the *participant* has reason to believe that any such payment is not so excludable.

## ARTICLE VIII

### ADMINISTRATION OF PLAN

#### 8.1 Appointment of Plan Administrator

Should the *employer* desire to appoint another person or entity other than itself from time to time as the *plan administrator*, it shall do so pursuant to instruments filed with the minutes of the *employer's* board of directors. The details of the appointment and the acceptance by the appointed person of the responsibilities of the *plan administrator* as set forth in the *Plan* shall be recorded in such instruments.

#### 8.2 Duties of Plan Administrator

The administration of the *Plan* shall be under the supervision of the *plan administrator*. The *plan administrator* shall have full power to administer the *Plan* in all of its details, subject to applicable requirements of law.

It shall be a principal duty of the *plan administrator* to see that the *Plan* is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in the *Plan*. For this purpose, the Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this *Plan* or by law:

- a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the *Plan*, including the establishment of any procedures that may be required by applicable provisions of law;
- b) To interpret the *Plan*, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the *Plan*;
- c) To decide all questions concerning the *Plan* and the eligibility of any person to participate in the *Plan*;
- d) To appoint such agents, counsels, accountants, consultants, and other persons as may be required to assist in the administration of the *Plan*; and
- e) To allocate and delegate its responsibilities under the *Plan* and to designate other persons to carry out any of its responsibilities under the *Plan*, any such allocation, delegation, or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under any one of the Constituent Plans shall not be subject to review under this *Plan*, and the *plan administrator's* authority under this Section shall not extend to any matter as to which a *plan administrator* under any such Constituent Plan is empowered to make determinations under such plan.

### 8.3 **Reliance by Plan Administrator**

In administering the *Plan*, the *plan administrator* shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the administrators of the Constituent Plans or by accountants, counsels, or other experts employed or engaged by the *plan administrator*.

### 8.4 **Notification**

The *plan administrator* shall ensure that all *employees* receive reasonable notification of their eligibility to become *participants* under this *Plan* and of the availability and terms of the *Plan*. The *plan administrator* shall notify *employees* of any changes in the terms of the *Plan* before the beginning of the *plan year* for which such changes are effective.

### 8.5 **Nondiscrimination**

This *Plan* is intended not to discriminate in favor of *highly compensated employees* as to eligibility to participate or as to contributions and benefits, as required by Section 125(b)(1) of the *code*, or in favor of *key employees* as to utilization, as required by Section 125(b)(2) of the *code*. If necessary, in the judgment of the *plan administrator*, the *plan administrator* shall impose conditions on the benefit elections of all *highly compensated employees* or *key employees*, as appropriate, sufficient to ensure compliance with such requirements or limitations.

### 8.6 **Fiscal Records**

The fiscal records of the *Plan* are to be maintained on the basis of the *plan year*. The *plan administrator* shall make available to any *employee* such records for the *Plan* as pertain to the *employee* for examination at reasonable times during normal business hours.

### 8.7 **Discretionary Authority**

Any discretion or judgment to be exercised by the *plan administrator* or other fiduciary shall be exercised in the *plan administrator's* or fiduciary's sole and absolute discretion.

Whenever, in the administration of the *Plan*, any discretionary action by the *plan administrator* is required, the *plan administrator* shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

#### 8.8 **Indemnification of Plan Administrator**

The *employer* agrees to indemnify and to defend to the fullest extent permitted by law any *employee* who serves as the *plan administrator* or as a member of a committee designated as *plan administrator*, including any Employee or former Employee who formerly served as *plan administrator* or as a member of such committee, against all liabilities, damages, costs, and expenses, including attorneys' fees and amounts paid in settlement of any claims approved by the *employer*, occasioned by any act or omission to act in connection with the *Plan*, if such act or omission was in good faith.

#### 8.9 **Government Reporting**

The *plan administrator* shall timely file with proper governmental authorities any and all forms and documents regarding the *Plan* that may be required under the *code* or other relevant laws and regulations.

#### 8.10 **Availability of Plan Document**

A copy of the *Plan* document is available for inspection during normal business hours at the offices of the *plan administrator*.

## ARTICLE IX

### GENERAL PROVISIONS

#### 9.1 Information to Be Furnished

*Participants* shall provide the *employer* and the *plan administrator* with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the *Plan*.

#### 9.2 No Vested Interest

Except for the right to receive any benefit payable under a Constituent Plan, no person shall have any right, title, or interest in or to the assets of the *employer* because of the *Plan*.

#### 9.3 Nonalienation of Benefits

Except as otherwise provided by law, the benefits provided under the *Plan* shall not be subject to assignment, anticipation, alienation, attachment, levy, or transfer, and any attempt to do so shall not be recognized.

#### 9.4 Not a Contract of Employment

Participation hereunder shall not grant any *participant* the right to be retained in the service of the *employer* or any other right or interest except as specifically set forth in the Constituent Plans or herein.

#### 9.5 Limitation of Rights

Neither the establishment of the *Plan* nor any amendment thereof, nor the payment of any benefits under the Constituent Plans, shall be construed as giving to any participant or any other person any legal or equitable right against the *employer* or *plan administrator*, except as provided herein.

#### 9.6 Amendment and Termination

The *employer* has established this *Plan* with the intention and expectation that it will be continued for an indefinite period of time. The *employer* shall, however, have no obligation to maintain the *Plan* for any given length of time and may alter, amend, or terminate this *Plan*, in whole or in part, at any time without liability provided, however, that the *employer* shall not alter, amend, or terminate this *Plan* so as to affect benefits to which *participants* are entitled before the date of such alteration, amendment, or termination.

## 9.7 **Invalid Provisions**

In the event any provisions of this *Plan* shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining Sections of this *Plan*, and this *Plan* shall be construed and enforced as if said illegal or invalid provision had never been inserted herein.

## 9.8 **No Guarantee of Tax Consequences**

Neither the *plan administrator* nor the *employer* makes any commitment or guarantee that any amounts paid to or for the benefit of a *participant* under this *plan* will be excludable from the *participant's* gross income for federal, state, or local income tax purposes or that any other federal, state, or local tax treatment will apply to or be available to any *participant*. It shall be the obligation of each *participant* to determine whether such payments are excludable from his or her gross income for federal, state, or local income tax purpose and to notify the employer if the *participant* has reason to believe that any such payment is not so excludable.

## 9.9 **Governing Law**

This *Plan* shall be governed by and construed in accordance with applicable federal laws and state laws.

## ARTICLE X

### PROTECTED HEALTH INFORMATION

#### 10.1 Protected Health Information

This Employee Benefit *Plan* collects and maintains a great deal of personal health information about you and your dependents. Federal HIPAA regulations on privacy and confidentiality limit how an Employee Benefit *Plan* and its *plan administrator* may use and disclose this information. This Article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

#### 10.2 Definitions

For purposes of this Article, the following terms shall have the meaning set forth below unless otherwise provided by the *Plan*:

a) **Electronic Protected Health Information**

Electronic Protected Health Information means Protected Health Information that is transmitted or maintained in any electronic media.

b) **HIPAA**

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

c) **Member**

Member means a covered employee or the covered dependents of a covered employee.

d) **Plan Documents**

*Plan Documents* means the *Plan's* governing documents and instruments (i.e., the documents under which the *Plan* was established and is maintained), including but not limited to the Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account Document.

e) **Plan Sponsor**

Plan Sponsor is Lincoln University of the Commonwealth System of Higher Education.

f) **Plan**

*Plan* is Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account.

g) **Protected Health Information**

Protected Health Information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify a member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information:

- i) Names;
- ii) Street address, city, county, precinct, zip code;
- iii) Dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;
- iv) Telephone numbers, fax numbers, and electronic mail addresses;
- v) Social Security numbers;
- vi) Medical record numbers;
- vii) Health plan beneficiary numbers;
- viii) Account numbers;
- ix) Certificate/license numbers;
- x) Vehicle identifiers and serial numbers, including license plate numbers;
- xi) Device identifiers and serial numbers;
- xii) Web universal resource locators (URLs);
- xiii) Biometric identifiers, including finger and voice prints;
- xiv) Full face photographic images and any comparable images; and
- xv) Any other unique identifying number, characteristic, or code.

h) **Regulation**

Regulation means the Health Insurance Portability and Accountability Act of 1996, as amended.

i) **Summary Health Information**

Summary Health Information means information that may be individually identifiable health information, and

- i) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a *Plan* sponsor has provided benefits under a group plan; and
- ii) From which the information described in the regulation has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

j) **Security Incidents**

Security Incidents means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. The *Plan* Sponsor will report a successful Security Incident to the *Plan* within a reasonable period of time after learning of the successful security incident. Data relating to an unsuccessful attempt may be aggregated and reported to the *Plan* on a less frequent basis.

10.3 **Permitted and Required Uses and Disclosure of Protected Health Information**

Subject to obtaining written certification this *Plan* may disclose Protected Health Information to the *Plan* Sponsor, provided the *Plan* Sponsor does not use or disclose such Protected Health Information except for the following purposes:

- a) Performing *Plan* administrative functions which the *Plan* Sponsor performs for the *Plan*.
- b) Obtaining bids for providing employee coverage under this *Plan*; or
- c) Modifying, amending, or terminating the *Plan*.

Notwithstanding the provisions of this *Plan* to the contrary, in no event shall the *Plan* Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the regulation.

#### 10.4 Conditions of Disclosure

The *Plan* or any employee coverage with respect to the *Plan*, shall not disclose Protected Health Information to the *Plan* Sponsor unless the *Plan* Sponsor agrees to:

- a) Not use or further disclose the Protected Health Information other than as permitted or required by the *Plan* or as required by law.
- b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the *Plan*, agree to the same restrictions and conditions that apply to the *Plan* Sponsor with respect to Protected Health Information.
- c) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan* Sponsor.
- d) Report to the *Plan* any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- e) Make available to a *Plan participant* who requests access the *Plan* participant's Protected Health Information in accordance with the Regulation.
- f) Make available to a *Plan participant* who requests an amendment to the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the Regulation.
- g) Make available to a *Plan participant* who request an accounting of disclosures of the *participant's* Protected Health Information the information required to provide an accounting of disclosures in accordance with the Regulation.
- h) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Secretary of Health and Human Services for purposes of determining compliance by the *Plan* with the Regulation.
- i) If feasible, return or destroy all Protected Health Information received from the *Plan* that the *Plan* Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- j) Ensure that the adequate separation between the *Plan* and the *Plan* Sponsor required in the Regulation is satisfied.

#### 10.5 **Certification of Plan Sponsor**

The *Plan* shall disclose Protected Health Information to the *Plan* Sponsor only upon the receipt of a Certification by the *Plan* Sponsor that the *Plan* has been amended to incorporate the provisions of the regulation, and that the *Plan* Sponsor agrees to the conditions of disclosure set forth in section 10.4.

#### 10.6 **Permitted Uses and Disclosure of Summary Health Information**

The *Plan* may disclose Summary Health Information to the *Plan* Sponsor, provided such Summary Health Information is only used by the *Plan* Sponsor for the purpose of:

- a) Obtaining bids for providing employee coverage under this *Plan*; or
- b) Modifying, amending, or terminating the *Plan*.

#### 10.7 **Permitted Uses and Disclosure of Enrollment and Disenrollment Information**

The *Plan* or a health insurance issuer or HMO with respect to the *Plan*, may disclose enrollment and disenrollment information and information on whether individuals are participating in the *Plan* to the *Plan* Sponsor, provided such enrollment and disenrollment information is only used by the *Plan* Sponsor for the purpose of performing administrative functions that the *Plan* Sponsor performs for the *Plan*.

#### 10.8 **Adequate Separation between the Plan and the Plan Sponsor**

The *Plan* Sponsor shall limit access to Protected Health Information to only those employees authorized by the *Plan* Sponsor. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the *Plan* Sponsor performs for the *Plan*. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the *Plan* Sponsor for non-compliance pursuant to the *Plan* Sponsor's employee discipline and termination procedures.

#### 10.9 **Security Standards For Electronic Protected Health Information**

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the *Plan* Sponsor on behalf of the *Plan*, the *Plan* Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- a) *Plan* Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that *Plan* Sponsor creates, receives, maintains, or transmits on behalf of the *Plan*;

- b) *Plan* Sponsor shall ensure that the adequate separation that is required by the Regulation is supported by reasonable and appropriate security measures;
- c) *Plan* Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- d) *Plan* Sponsor shall report to the *Plan* any Security Incidents of which it becomes aware as described below:
  - i) Sponsor shall report to the *Plan* any other Security Incident on an aggregate basis every month, or more frequently upon the *Plan's* request.
  - ii) This *Plan* will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164.

## ARTICLE XI

### ERISA STATEMENT OF RIGHTS (Employee Retirement Income Security Act of 1974)

As a *participant* in the Lincoln University of the Commonwealth System of Higher Education Flexible Spending Account, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all *Plan participants* shall be entitled to:

- a) Examine, without charge, at the *plan administrator's* office and at other specified locations, all plan documents, collective bargaining agreements and copies of all documents filed by the *Plan* with the U.S. Department of Labor, such as detailed annual reports.
- b) Obtain copies of all plan documents and other *Plan* information upon written request to the *plan administrator*. The Administrator may make a reasonable charge for the copies.
- c) In some cases, the law may require the *plan administrator* to provide you with a summary of the *Plan's* annual financial report.

In addition to creating rights for *Plan participants*, ERISA imposes duties upon the people who operate the *Plan*. These people are called fiduciaries and have a duty to act 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 or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the *plan administrator* review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you make a written request for materials from the *Plan* and do not receive them within thirty (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 up to \$110 per 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 a suit in federal court. If it should happen that the *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 a suit in 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 if it finds your claim is frivolous.

If you have any questions about your *Plan*, you should contact the *Plan Administrator*. If you have any questions about this statement or about your rights under ERISA, you should contact 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, DC 20210.