



# Flexible Spending Account and Premium Only Plan

Plan Document and  
Summary Plan Description



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## **St. John's University Flexible Spending**

### **Account and Premium Only Plan**

#### **Introduction**

We are pleased to announce that we have established a Flexible Spending Account and Premium Only Plan for you and other eligible employees. Under this plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights. St. John's University (the "University") fully intends to maintain this Plan indefinitely. However, the Plan Administrator reserves the right, subject to applicable collective bargaining agreements, to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

#### **Flexible Spending Account Program**

The Flexible Spending Account has two Options. You may elect to participate in the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account. The choice is yours. By electing the Health Care Reimbursement Account, you will be able to pay for certain non-covered expenses with pre-tax contributions. Details are in the Available Benefits Section of this Summary Plan Description (Section IV). Participation in the Dependent Care Reimbursement Account will enable you to pay for out of pocket work related dependent care costs, also with pre-tax contributions.

#### **Premium Only Program**

One of the most important features of the Premium Only Program is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to Federal income, Social Security, and unemployment taxes. Any premium contributions you are required to pay under our medical and/or dental plans will be paid for with a portion of your pay *before* Federal income, Social Security or unemployment taxes are withheld. This means that you will pay less tax and have more money to spend and save because the Premium Only Program allows your portion of the premium to be paid with pre-tax dollars.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a Plan Document on file with the Employee Services and Benefits Department, which you may review if you desire. If there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an insurance contract and either the Plan Document or this Summary Plan Description, the insurance contract will control. Any description of tax consequences in this Summary Plan Description relates only to applicable Federal taxes and is for general informational purposes only. There may or may not be additional Federal, state and/or local tax benefits or consequences of

participating in the Plan which are not described in this Summary Plan Description. Please remember that your Federal, state and local tax consequences depend on your individual circumstances. You should consult with your own personal tax advisor to understand the specific Federal, state and/or local tax consequences to you of participating in the Plan.

## I

### ELIGIBILITY

#### 1. When Can I Become a Participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements." After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan.

#### 2. What Are the Eligibility Requirements for Our Plan?

##### **Flexible Spending Account Program**

You will be eligible to join the Flexible Spending Account Program if you are a Full-Time Employee of St. John's University (i.e., normally working at least 30 hours per week and on the St. John's University regular payroll for such work).

##### **Premium Only Program**

You will be eligible to join the Premium Only Program if you are required to contribute towards the cost of medical or dental coverage.

#### 3. When Is My Entry Date?

You are eligible to participate in the Plan if you are actively at work and meet the eligibility requirements of the Plan. Your participation will begin as follows:

- a. if hired on the first of the month, coverage is immediate; or
- b. if hired on any other day in the month, coverage begins on the first of the following month.

#### 4. Are There Any Employees Who Are Not Eligible?

##### **Flexible Spending Account Program - Yes**

- a. part-time employees are *not* eligible.

##### **Premium Only Program - Yes**

- a. any employee not eligible to participate in the St. John's University medical or dental plan;

and

- b. part-time employees are *not* eligible.

#### 5. What Must I Do to Enroll in the Plan?

Before you can join either the Flexible Spending Account Program or Premium Only Program, you must complete an application to participate and submit this application to the Plan Administrator before the end of the applicable election period. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

#### 6. When Will My Participation in the Plan End?

You will cease to participate in the Plan as of the earlier of:

- a. the date you no longer satisfy the eligibility requirements set forth above;
- b. the end of the period for which you last made a contribution under the Plan;
- c. the effective date of any applicable Plan amendment; or
- d. the effective date of the Plan's termination

## II

### OPERATION

#### 1. Flexible Spending Account Program

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. The portion of your pay that is paid to the Plan is not subject to Federal income, Social Security or unemployment taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out of pocket, *taxable* dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return for these amounts.

#### 2. Premium Only Program

We will deduct from your pay the required premium contributions for the medical and/or dental plans. The portion of your pay that is deducted is not subject to Federal income, Social Security or unemployment taxes.

### III

## CONTRIBUTIONS

#### 1. How Much of My Pay May I Request St. John's University to Redirect?

##### **Flexible Spending Account Program**

Each year, you may elect to have us contribute on your behalf a portion of your compensation to pay for non-reimbursed medical care or dependent care expenses. The amounts you elect will be deducted from your pay over the course of the year. For the Flexible Spending Accounts, the maximum amount of annual contributions you can make is:

- a. Health Care Reimbursement Account .....\$3,000
- b. Dependent Care Reimbursement Account ..... \$5,000

##### **Premium Only Program**

For the Premium Only Program, we will deduct from your pay the required premium contributions for the medical and/or dental plans.

#### 2. What Happens to Contributions Made to the Flexible Spending Accounts?

Your contributions will be used to pay for non-reimbursed medical care or dependent care expenses as they arise during the year. However, if you over project your non-reimbursed expenses for the Plan Year, any unused contributions will be forfeited. Thus, it is very important that you take the time to carefully (and conservatively) project your non-reimbursed medical care or dependent care expenses for an upcoming Plan Year.

#### 3. When is the "Election Period" for Our Plan?

Your initial election period will *start* on the date you first meet the "eligibility requirements" and *end* 30 days after your potential "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is established by the Plan Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Plan Administrator will inform you each year about the election period. (See the Section VIII entitled "Other Information About Our Plan" for the definition of Plan Year.)

#### 4. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. Note that, unless you make an election to participate for that Plan Year, you will *not* be enrolled in the plan for that Plan Year.

## **Flexible Spending Account Program**

If you do not make new elections during the "election period" before a new Plan Year begins, we will assume you do not want your elections to remain the same, and you will *not* be considered a participant in the Program for that Plan Year. If you want to continue in the Program, you must *re-enroll each year*.

## **Premium Only Program**

If you do not make new elections during the "election period" before a new Plan Year begins, we will assume you want your elections to remain the same. You will be considered to be a participant in the Premium Only Program for the upcoming year unless you tell us otherwise in writing.

### **5. May I Change My Elections during the Plan Year?**

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change if there is a change in your "family status." Currently, Federal law considers the following events to be examples of a change in family status:

- a. you get married, divorced, obtain a legal separation or annulment;
- b. you have a child, adopt one, or place a child for adoption;
- c. your spouse and/or child dies;
- d. your spouse commences or terminates employment;
- e. your spouse's or your employment status changes from full time to part time or from part time to full time;
- f. you or your spouse take an unpaid leave of absence;
- g. your spouse has a significant change in health coverage directly attributable to your spouse's employment.
- h. you or your spouse's worksite changes
- i. a strike or lockout
- j. you or your spouse's place of residence changes
- k. in order to comply with a Qualified Medical Child Support Order (QMCSO)

There may be other events, which are considered to be changes in family status. Also, any election change must be consistent with the reason that such change was permitted.

You may increase your benefit election as a result of a change in family status; however, your new annual contribution plus any reimbursed amount claimed to date may not exceed the maximum annual contribution for the plan.

To change your benefit elections after a change in family status, you must submit certain completed forms to the Plan Administrator within 31 days of the change in family status. If for any reason you do not submit the completed forms to the Plan Administrator within this time period, your election(s) changes will not be effective and, unless you experience another change in family status during the Plan Year, you will not be permitted to change your benefit elections until the following Plan Year. If you have a change in family status, you should contact the Plan Administrator, who will provide you with the required forms for changing your benefit elections.

## IV

### AVAILABLE BENEFITS

#### 1. Health Care Reimbursement Account:

The Health Care Reimbursement Account enables you to pay for expenses, which are not covered by our medical and/or dental plans and save taxes at the same time. The account allows you to be reimbursed by St. John's University for out of pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those incurred for "medical care" within the meaning of Section 213(d)(1) of the Internal Revenue Code. A list of covered expenses is available from the Plan Administrator.

You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the medical plans, or for long-term care expenses.

The most that you can contribute to your Health Care Reimbursement Account each Plan Year is \$3000. In order to be reimbursed for a medical care expense, you must submit to the Claims Administrator an itemized bill from the service provider. Amounts reimbursed from the Account may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid once a month.

#### 2. Dependent Care Reimbursement Account:

The Dependent Care Reimbursement Account enables you to pay for out of pocket, work related dependent day care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full time. Single employees can also use the account.

An eligible dependent is someone who is:

A child under age 13 that you are entitled to deduct on your income tax return;

A spouse of any age who is physically or mentally incapable of self-support who regularly spends at least eight hours a day in your household and who shares the same principal residence with you for more than one-half of the year; or

A dependent of any age who is physically or mentally incapable of self support, who regularly spends at least eight hours a day in your household, who shares the same principal residence with you for more than one-half of the year and is either:

1. under age 19 or a full time student under age 24 at the end of the year, or permanently and totally disabled, and they do not provide over one-half of their own support; or
2. any age if you provide over one-half of their support and they earn less than a specified amount during the year (\$3,300 for 2006)

Dependent Care arrangements, which qualify include:

- a. a Dependent Day Care Center which is fully compliant with applicable state and local laws  
or
- b. an Educational Institution (below kindergarten level) for pre-school children (all expenses eligible)  
or
- c. an Educational Institution (kindergarten level and higher) for older school children (only non-school expenses eligible)  
or
- d. Day camps or similar programs  
or
- d. an "Individual" providing care inside or outside your home.

*(Note that "Individual" in d., above must not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.)*

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Reimbursement Account. Generally, your reimbursements may not exceed the lesser of:

- a. \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns);
- b. your taxable compensation; or
- c. your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one

dependent or \$500 for two or more dependents. These amounts are updated annually by the IRS).

Also, in order to have the reimbursements made to you from this account be excludable from your Federal income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may pay even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Reimbursement Account under our Plan. Ask your tax adviser which is better for you.

### 3. Premium Only Program

The Premium Only Program allows you to use tax-free dollars to pay for certain premium contribution expenses under medical and/or dental insurance programs that we offer you. These expenses include:

a. health care premiums you are required to pay,

or

b. dental care premiums you are required to pay.

Under our Plan, we will establish sub accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Plan Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your plan benefits will end when you leave employment, are no longer eligible under the terms of any coverage or when coverage terminates.

## V

### **BENEFIT PAYMENTS**

#### 1. When Will I Receive Payments From My Flexible Spending Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment. Reimbursement payments are processed monthly. Remember, these reimbursements, which are made from the Plan are generally not subject to Federal income tax or withholding. Nor are they subject to Federal Social Security or unemployment taxes. You will be reimbursed from the Dependent Care Reimbursement Account only to the extent that there are sufficient funds in the Account to cover your request.

## 2. What Happens if I Don't Spend Everything in My Flexible Spending Account?

Any money left at the end of the Plan Year will be forfeited. Qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide carefully and conservatively as to how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up *entirely*.

## 3. What Happens if I Terminate Employment?

### **Flexible Spending Account Program**

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

- a. Your participation in the Health Care Reimbursement Account will cease, and no further salary reductions will be made on your behalf. However, you will be able to submit claims for medical care expenses incurred prior to your date of termination.
- b. You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary reduction contributions will be made on your behalf after you terminate.

### **Premium Only Program**

If you leave our employ during the Plan Year, your right to benefits will cease and no further salary deductions will be made.

## 4. Children Pursuant to a Qualified Medical Child Support Order (“QMCSO”)

You or your beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator.

## 5. COBRA Continuation Options

COBRA applies to the Healthcare Reimbursement Account and not to the Dependent Care Account or Premium Only Program. If you decide to elect continuation of your Healthcare Reimbursement Account under COBRA, you will make your contributions on an after tax basis. Federal law gives certain persons the right to temporarily continue their health care benefits beyond the date that they might otherwise terminate, but not beyond the current coverage period. Specifically, such persons

will be eligible for COBRA continuation coverage only if they have a positive Healthcare Reimbursement Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such persons will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the coverage period in which the qualifying event occurs.) The entire cost of such coverage (plus a reasonable administration fee) must be paid by the continuing person. This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The Plan Administrator will provide complete instructions on COBRA to Plan Participants who become qualified beneficiaries under COBRA.

#### 6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced, because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Federal Social Security on your behalf.

## VI

### CLAIM FOR BENEFITS

P & A Group is the Claims Administrator for medical or dependent care expense payments under your spending account. Any claim for medical or dependent care spending account benefits must be submitted to the Claims Administrator (see "*Claims Administrator*" under section titled "*Other Information About Our Plans*" in this document). If your claim is denied, you or your beneficiary must follow the claim determination and appeal procedures.

#### 1. Claim Determination and Appeal Procedures for the Health Care Reimbursement Account:

##### TIME FRAME FOR INITIAL CLAIM DETERMINATION

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claims Administrator will notify you of the adverse determination within 30 days after receiving the claim.

This 30-day period may be extended for up to an additional 15 days, if the Claims Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 30-day period expires, of the special circumstances requiring an extension of time and the date by which the Plan expects to render a determination. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim. The Plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claims Administrator sends you the extension notification until the date you respond to the request for additional information.

##### CONCURRENT CARE CLAIMS

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments any reduction or termination by the Plan of such course of treatment shall constitute an adverse benefit decision except as provided below.

NOTE: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment (any additional or revised provisions or benefits to the Plan provided as a written attachment to this SPD) or Plan termination.

#### IF YOU RECEIVE AN ADVERSE BENEFIT DETERMINATION

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- a. The specific reason(s) for the adverse benefit determination;
- b. Reference to the specific Plan provisions on which the benefit determination is based;
- c. A description of any additional material or information needed to perfect the claim and an explanation of why that material or information is necessary; and
- d. A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after an adverse determination on appeal;
- e. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- f. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

#### PROCEDURES FOR APPEALING AN ADVERSE BENEFIT DETERMINATION

If you receive an adverse benefit determination, you may ask for a review. You, or our authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- a. Submit written comments, documents, records and other information relating to the claim for benefits;
- b. Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
  - (1) Was relied upon in making the benefit determination;
  - (2) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination;

- (3) Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; or
  - (4) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- c. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;
  - d. A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate;
  - e. A review in which the Claims Administrator (first level appeals) and the Plan Administrator (second level appeals) consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. You consent to this referral and the sharing of pertinent medical claim information. This paragraph e. applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental); and
  - f. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

The first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision with 30 days from receipt of a request for review of the first level appeal process.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

A notice of adverse benefit determination on appeal will contain all of the following information:

- a. The specific reason(s) for the adverse benefit determination;
- b. References to the specific Plan provisions on which the benefit determination is based;
- c. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- d. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under section 502(a) of ERISA;

- e. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request; and
- f. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to our medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Please note: any decision under the Plan is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether any specific health service is necessary or appropriate is between you and your physician.

## 2. Claim Determination and Appeal Procedures for the Dependent Care Reimbursement Account:

### TIME FRAME FOR INITIAL CLAIM DETERMINATION

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claims Administrator will notify you of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Claims Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring an extension of time and the date by which the Plan expects to render a determination.

In the event that an extension is necessary due to your failure to submit necessary information, the Plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claims Administrator sends you the extension notification until the date you respond to the request for additional information.

### IF YOU RECEIVE AN ADVERSE BENEFIT DETERMINATION

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- a. The specific reason(s) for the adverse benefit determination;
- b. Reference to the specific Plan provisions on which the benefit determination is based;
- c. A description of any additional material or information needed to perfect the claim and an explanation of why that material or information is necessary; and
- d. A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after an adverse determination on appeal.

### PROCEDURES FOR APPEALING AN ADVERSE BENEFIT DETERMINATION

You, or our authorized representative, have 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- a. Submit written comments, documents, records and other information relating to the claim for benefits;
- b. Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - (1) Was relied upon in making the benefit determination;
  - (2) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefits determination; or
  - (3) Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination.
- c. A review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator must notify you of the Plan’s benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review. This 60-day period may be extended for up to an additional 60 days, if the Claims Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination on review

In the event an extension is necessary due to your failure to submit necessary information, the Plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claims Administrator sends you the extension notification until the date you respond to the request for additional information.

The Claims Administrator’s notice of adverse benefit determination on appeal will contain all of the following information:

- a. The specific reason(s) for the adverse benefit determination;
- b. References to the specific Plan provisions on which the benefit determination is based;
- c. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- d. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under section 502(a) of ERISA.

## **PLAN ACCOUNTING**

### **Periodic Statements**

Periodically during the Plan Year, the Claims Administrator will provide you with statements showing your flexible spending account balance(s). It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year; otherwise you will forfeit the remaining balance(s).

## VIII

### OTHER INFORMATION ABOUT OUR PLAN

#### 1. General Plan Information

Name of Plan	St. John's University Flexible Spending Account And Premium Only Plan
Plan Number	502
Plan Year	The Plan's fiscal records are kept on a calendar year basis beginning January 1 and ending on December 31.
Type of Plan	Flexible Spending Account and Premium Only Plan

#### 2. Employer Information

Employer Name	St. John's University
Employer Identification Number	11-1630830

#### 3. Plan Administrator

Director, Employee Benefits  
St. John's University  
8000 Utopia Parkway  
Jamaica, New York 11439  
Telephone (718) 990-6587

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about our Plan.

#### 4. Agent for Service of Legal Process

St. John's University  
Attn: General Counsel  
8000 Utopia Parkway  
Jamaica, New York 11439

#### 5. Claims Administrator

P & A Group  
17 Court Street  
Suite 500  
Buffalo, NY 14202-3204  
Telephone (877) 855-7105

## IX

### ADDITIONAL PLAN INFORMATION

#### Statement of ERISA Rights

- A. As a participant in St. John's University Flexible Spending Account and Premium Only 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. Examine, without charge, at 8000 Utopia Parkway, Jamaica, New York 11439 all Plan documents filed with the U.S. Department of Labor, such as Plan descriptions. If you wish to examine any of the Plan documents outside the company's office, you must submit a written request to:  
  

**St. John's University**  
**8000 Utopia Parkway**  
**Jamaica, New York 11439**
  2. Obtain copies of all Plan documents and other Plan information on written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
  3. 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.
- B. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an insurance benefit or exercising your rights under ERISA. If your claim for an employee 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 your claim reviewed and reconsidered upon request.
- C. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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.
- D. 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. (However, see the section titled Claim For Benefits in

this document, which provides for a claims review procedure that must be followed before you may file a suit.) If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

- E. 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 Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

## **X**

### **SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator.