ST. JOHN'S UNIVERSITY

FLEXIBLE BENEFITS PLAN
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ARTICLE I: INTRODUCTION

1.1 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. This document restates the cafeteria plan heretofore maintained by the Employer.

1.2 Purpose of Plan. The purpose of this Plan is to provide employees of the Employer with a choice between cash and certain qualifying non-cash benefits under the benefit plans and arrangements of the Employer.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 Administrator" means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.3 "Compensation" means any wages, salary or other amounts paid in cash by the Employer and reportable on a Participant's Form W-2.

2.4 "Component Plans" means the Insurance Plans and Flexible Spending Account Plans of the Employer.

2.5 "Deemed Election" means the election of benefits that a Participant will be deemed to have made if he or she fails to file a completed election form for any Period of Coverage on or before the deadline set by the Administrator. A Participant's failure to timely file a completed election form for his or her initial Period of Coverage under the Plan shall constitute an election of all benefits under the Insurance Premium Pre-Tax Payment Option (and a corresponding agreement to a reduction in the Participant's share of the cost during such Period of Coverage of each such benefit) and an election not to receive any benefits under any of the Flexible Spending Account Plans. A Participant's failure to timely file a completed election form for any subsequent Period of Coverage shall constitute (a) a re-election of the same benefits, if any, as the Participant had elected (including any benefits elected pursuant to a Deemed Election) under the Insurance Premium Pre-Tax Payment Option for the immediately preceding Period of Coverage and a corresponding agreement to a reduction in the Participant's Compensation during the Period of Coverage equal to the Participant's share of the cost of such benefits, and (b) an election to not receive any benefits under any of the Flexible Spending Account Plans.

2.6 "Dependent" means any individual who is a dependent of the Participant as defined in Code §152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Individual Premium Pre-Tax Payment Option), and for purposes of the Medical Expense Reimbursement Plan, (1) a dependent is defined as in Code §152, determined without regard to
subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the Medical Expense Reimbursement Plan will provide benefits in accordance with the applicable requirements of any qualified medical support order as defined in Section 609 pf ERISA even if the child does not meet the definition of “Dependent” and (b) for purposes of the Dependent Care Assistance Program, a Dependent means a “qualifying individual” as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, a qualifying individual who is a child shall, as provided in Code §21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent.

2.7 "Dependent Care Service Provider" means a person who provides care or other services described in Section 2.25, but shall not include (a) a dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.

2.8 “Effective Date” means January 1, 2005.

2.9 "Eligible Employee" means an Employee who is of the type, category or classification that is eligible to make an election of benefits under the Plan upon satisfying the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, under the Plan. Every Employee who regularly is scheduled to work a minimum of thirty five hours per week for the Employer and who is not classified by the Employer as a “part-time” employee is an Eligible Employee.

2.10 "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer’s W-2 payroll, or any individual who performs services for the Employer but is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

For purposes of this Plan, the following individuals shall be not be considered Employees:

(a) If the Employer is an S Corporation, any "2-percent shareholder" of the Employer, as that term is defined by Code Section 1372(b),

(b) If the Employer is a partnership or is taxed as a partnership under federal tax law, any partner, member or owner in the Employer.

(c) If the Employer is a sole proprietorship, the owner of the Employer.

2.11 "Employer" means St. John’s University, and any other corporation, partnership, firm or business which, with the permission of St. John’s University, adopts the Plan, provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan), the term "Employer" shall mean only St. John’s University. Other parties that adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation therein.
"Flexible Spending Account Plan" means the Medical Expense Reimbursement Plan or the Dependent Care Assistance Plan of the Employer, as established under Article V of this Plan.

"Inactive Participant" means an individual whose status as a Participant in a Flexible Spending Account Plan has terminated, but who continues to have certain rights to reimbursement under that Plan, in accordance with Section 5.15 of the Plan.

"Insurance Plan" means any of the plans, programs and arrangements made available by or through the Employer pursuant to which Employees may obtain insurance (or Health Maintenance Organization) coverage of the following types: medical, dental, disability income and term life.

"Insurance Premium Pre-Tax Payment Option" means the option afforded a Participant under the Plan to elect to pay, on a pre-tax basis, his or her share of the cost of coverage under the Insurance Plans.

"Key Employee" means any person who is a key employee, as defined in Section 416(i)(1) of the Code, with respect to the Employer.

"Minimum Age Requirement" means the age, if any, that an Eligible Employee must attain as a condition to becoming a Participant. There is no Minimum Age Requirement.

"Minimum Service Requirement" means the period of continuous employment with the Employer, if any, that an Eligible Employee must complete as a condition to becoming a Participant. There is no Minimum Service Requirement.

"Participant" means any Eligible Employee who has satisfied the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, and whose Participant Commencement Date has occurred.

"Participation Commencement Date" means the date on which an Eligible Employee becomes a Participant, which is (i) the first day of the month coinciding with or following the date on which his or her employment with the Employer commenced or (ii) the Effective Date, whichever is the last to occur.

“Period of Coverage” means the Plan Year, except as follows: (i) The Period of Coverage for a first-time Participant shall be the period commencing on his or her Participation Commencement Date and ending on the last day of the Plan Year within which his or her Participation Commencement Date occurs, and (ii) The Period of Coverage for a Participant whose participation ceases in accordance with Section 3.2 shall be the period from the first day of the Plan Year within which his or her participation ceases and ending on the date his or her participation ceases.

"Plan" means the St. John’s University Flexible Benefits Plan as set forth herein, together with any and all amendments and supplements hereto.

"Plan Year" means the recurring period on which the records of the Plan are maintained, which is each twelve-month period beginning on January 1 and ending December 31.

"Qualifying Dependent Care Expense" mean an expense incurred by a Participant which (a) is incurred for the care of a Qualifying Individual of the Participant or for related household services, (b) is paid or payable to a Dependent Care Service Provider, and (c) is incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to the Participant. "Qualifying Dependent Care Expense" shall not include an expense
incurred for (i) services outside the Participant's household for the care of a Qualifying Individual, unless such Qualifying Individual is described in "(a)" above or regularly spends at least eight hours each day in the Participant's household, or (ii) services at a camp where the Qualifying Individual stays overnight.

2.25 "Qualifying Expense" means a Qualifying Dependent Care Expense or Qualifying Medical Care Expense.

2.26 "Qualifying Individual" means (a) a Participant's Dependent who is under the age of thirteen (and meets other conditions imposed by the definition of Dependent, such as a requirement that he or she have the same principal place of abode as the Participant); (b) a Participant's Dependent who is physically or mentally incapable of self-care, has the same principal place of abode as the Participant for more than half of the year, and meets other conditions imposed by the definition of Dependent and (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

2.27 "Qualifying Medical Care Expense" means an expense incurred by a Participant, or by the spouse or of such Participant, for medical care as defined in Section 213(d) of the Code (including, without limitation, amounts paid for hospital bills, doctor, dental or vision care bills and drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under the Plan). "Qualifying Medical Care Expense" shall not include any premium paid for health coverage under any plan maintained by the Employer or any other employer.
ARTICLE III: PARTICIPATION

3.1 Commencement of Participation. An Eligible Employee shall become a Participant, thus entitling him or her to make an election of benefits under the Plan, on his or her Participation Commencement Date.

3.2 Cessation of Participation. A Participant shall cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date he or she ceases to be an Eligible Employee. Except as otherwise provided herein, any election made under this Plan (including any Deemed Election) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a Component Plan may continue if and to the extent provided by such Plan.

3.3 Reinstatement of Former Participant. A former Participant will become a Participant again if and when he or she becomes an Eligible Employee. However, in the case of a former Participant whose election terminates due to separation from service with the Employer, if such person should return to service within thirty days thereafter, he or she will be prohibited from making a new benefit election for the remainder of the Plan Year.

3.4 Leaves of Absence. Subject to any specific limitations for any particular benefit which the Participant has elected:

(a) A Participant’s election shall remain in force during a paid leave of absence, i.e., one for which the Participant continues to receive a salary from the Employer.

(b) A Participant who takes an unpaid leave of absence may revoke his or her existing election and execute a new election for the remainder of the Plan Year to the extent permitted by Section 4.5 below.

(c) Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by FMLA, the Employer will continue to maintain the Participant’s benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though he were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee elects to continue his or her coverage). If the Employee elects to continue his or her coverage, the Employee may pay his or her share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent the Employee receives Compensation during the leave), or the Employee may be given the option to prepay all or a portion of the Employee’s share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of the Employee’s pre-leave Compensation by making a special election to that effect prior to the date such Compensation normally would be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreed upon by the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee’s return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating prior to taking leave, or as otherwise required by the FMLA, and shall have whatever rights as shall be applicable under Section 4.5.
ARTICLE IV: BENEFIT OPTIONS

4.1 Benefit Options. Each Participant may choose under this Plan to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Employer toward the cost of benefits under one or more of the Component Plans.

4.2 Insurance Premium Pre-Tax Payment Option; Description of Benefits under the Insurance Plans. The benefits directly available to Participants under this Plan relative to the Insurance Plans are limited to the Insurance Premium Pre-Tax Payment Option. The types and amounts of insurance benefits available, the eligibility requirements and the other terms and conditions of coverage under the Insurance Plans are as set forth from time to time in those Plans and in the group insurance contracts and prepaid health plan contracts that may constitute (or may be incorporated by reference in) those Plans.

4.3 Election Procedure.

(a) New Participants. The Administrator shall provide an Eligible Employee with a Flexible Compensation Enrollment Form and Salary Deduction Agreement (or “election form”) before, or as soon as practicable after, his or her Participation Commencement Date (or he or she qualifies to make a new election of benefits pursuant to Section 3.3). The Eligible Employee shall specify on the election form those benefits he or she elects for the Period of Coverage to which the election form relates and shall agree to a reduction in his or her Compensation to the extent necessary to pay for the cost on benefits elected under the Component Plans.

(b) Annual Enrollment and Election Changes. Before the beginning of each Plan Year, the Administrator shall provide an election form to each Eligible Employee who is scheduled to be a Participant on the first day of that Plan Year. This election form shall enable the Participant to make a new election of benefits under the Plan as of the first pay period commencing on or after the first day of the Plan Year. The Participant shall specify on the election form those benefits he or she elects for the Period of Coverage commencing with that Plan Year and shall agree to a reduction in his or her Compensation to the extent necessary to pay for the cost on benefits elected under the Component Plans.

(c) Deadline for Return of Election Form. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period to which the election form is to apply.

(d) Failure to Return Election Forms—Deemed Election. A Participant’s failure to return a completed election form to the Administrator on or before the specified due date shall constitute a Deemed Election of benefits under the Plan.

4.4 Election of Component Plan Benefits in Lieu of Cash. If a Participant elects benefits for a Period of Coverage under any of the Component Plans, his or her Compensation for the Period of Coverage shall be reduced to pay for those benefits. In the case of benefits elected under any Insurance Plan, the Compensation reduction shall equal the Participant’s share of the cost of coverage under that Plan. In the case of benefits elected under any Flexible Spending Account Plan, the Compensation reduction shall equal the amount of benefits elected by the Participant under that Plan.

4.5 Irrevocability of Elections. A Participant may not revoke any election made under the Plan during the Period of Coverage to which it pertains, except as follows.

(a) A Participant may change his or her election for the balance of the Period of Coverage if, under the facts and circumstances, a Change in Status occurs and the change of election satisfies the applicable consistency requirement, as set forth below. For this purpose, a “Change in Status” consists of one of the following events:
(1) A change in the Participant’s legal status, including marriage, death of the Participant’s spouse, divorce, legal separation or annulment.

(2) A change in the number of dependents that the Participant has for federal income tax purposes, as determined under Code Section 152, due to events that include birth, adoption, placement for adoption or death.

(3) A termination or commencement of employment by the spouse or a dependent of the Participant.

(4) A reduction or increase in the hours of employment by the Participant or the spouse or dependent of the Participant, including a switch between part-time and full-time, a strike or lockout and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan of the Employer, or of any cafeteria plan or other employee benefit plan of the employer of the Participant’s spouse or dependent depend on the employment status of that individual and there is a change in that individual’s employment status with the consequence that the individual becomes or ceases to be eligible under the plan, that change constitutes a Change in Status.

(5) An event that causes the Participant’s dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the accident or health plan under which the Participant receives coverage.

(6) A change in the place of residence or work of the Participant or of the spouse or dependent of the Participant.

A Participant’s change of election is consistent with a Change in Status only if, (i) the Change in Status results in the Participant or the Participant’s spouse or dependent gaining or losing eligibility under the Plan or under a plan of the spouse’s or dependent’s employer, and (ii) the change of election corresponds with that gain or loss of coverage, or if the Change of Status affects dependent care expenses described in Code Section 129.

If the Change of Status is a Participant’s divorce, annulment or legal separation, the death of a Participant’s spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, the Participant’s election under the Plan to cancel accident or health coverage for any individual other than the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent or the dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, fails to correspond with that Change in Status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the election to cancel accident or health coverage for any other dependent, for the Participant or for the Participant’s spouse fails to correspond with that Change in Status. In addition, if a Participant, spouse or dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are qualified benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes applicable or is increased under the plan from which eligibility for coverage has been gained. Provided, however, an election to increase or decrease disability insurance coverage may correspond with any Change in Status.

If the Participant or the spouse or dependent of the Participant becomes eligible for continuation coverage under a group health plan of the Employer as provided in Section 4980B of the Code or any similar state law, the Participant may elect to increase payments under this Plan to pay for the continuation coverage.
(b) A Participant may change his or her election for the balance of the Period of Coverage and file a new election that corresponds with special enrollment rights of the Participant under Section 9801(f) of the Code.

(c) In the event of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order as defined under applicable law that requires accident or health coverage for a Participant’s child or for a foster child who is a dependent of a Participant, the Participant may:

(1) change his or her election to provide coverage for the child if the judgment, decree or order requires coverage under the Employer’s accident or health plan; or

(2) make a change of election to cancel coverage for the child if the order requires the spouse or former spouse of the Participant or any other person to provide coverage for the child.

(d) If a Participant, or the spouse or dependent of a Participant, who is enrolled in an accident or health plan of the Employer becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), he or she may make a prospective change of election to cancel his or her coverage under the accident or health plan of the Employer. In addition, if a Participant, spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective change of election to commence or to increase the coverage of that Participant, spouse or dependent under the accident or health plan.

(e) A change of cost or change of coverage with respect to benefits under any Component Plan may be the basis for a change of election in accordance with the following:

(1) The rules under this Section 4.5(e) shall not apply to benefits under the Medical Expense Reimbursement Plan.

(2) If the cost of a Participant’s benefits under any Component Plan increases or decreases during a period of coverage and, under the terms of that Component Plan, employees are required to make a corresponding change in their payments, a corresponding adjustment shall be made to the Participant’s elective contributions under this Plan, subject, however, to (3) below.

(3) If the cost of a Participant's benefits under a Component Plan significantly increases during a period of coverage, the Participant may elect either to increase his or her contributions to pay for the increased cost or may revoke his or her election and, in lieu thereof, receive on a prospective basis, coverage under another benefit option available under the Component Plan. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which a Participant has elected that benefit or benefit option, a Participant may make a new election of that benefit or benefit option. If a Participant has an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect that benefit option that has significantly decreased in cost.

(4) Notwithstanding the foregoing, a cost change shall only provide the basis for an election change with respect to dependent care assistance benefits if the cost change is imposed by a dependent care provider who is not a “relative” of the Participant as that term is defined under Code Section 152.
(5) If a Participant’s coverage under any Component Plan is significantly curtailed or ceases during a period of coverage, the Participant may revoke his or her existing election of the coverage and may make a new election on a prospective basis of any other coverage option available under that Component Plan. Coverage under an accident or health plan shall be considered as curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(6) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Participant’s spouse, former spouse or dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules and if that plan permits participants to make an election for a period of coverage under the cafeteria or other plan that is different than that under this Plan.

(f) A Participant may revoke a prior election and make a new election where there has been a significant change in the health coverage of the participant or the Participant’s spouse attributable to the spouse’s employment, provided such change of election is determined by the Administrator to be consistent with the change in health coverage.

(g) A Participant taking leave under the FMLA may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(h) The Change in Status rules do not apply with respect to elective contributions under the qualified cash or deferred arrangement as defined in Code Section 401(k).

Notwithstanding any provision herein to the contrary, no Participant may reduce his or her election for benefits under any Flexible Spending Account Plan below the amount already reimbursed under such Plan for the Period of Coverage.

Any revocation and new election under this Section 4.5 shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the revocation and new election.

Any election under this Section 4.5 must be filed within thirty days of the occurrence of the Change in Status to which the election relates.

4.6 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.7 Maximum Employer Contributions. The maximum amount of employer contributions under the Plan for any Participant shall be the sum of (i) the costs from time to time of the most expensive benefits available to the Participant under the Insurance Premium Pre-Tax Payment Option, and (ii) the maximum amount that may be contributed for benefits under the Flexible Spending Account Plans.
ARTICLE V: FLEXIBLE SPENDING ACCOUNT BENEFITS

5.1 Flexible Spending Account Options. The Plan shall provide, through the mechanism of a "Flexible Spending Account", as that term is defined in proposed tax regulations under Section 125, for the payment, on a pre-tax basis, of certain out-of-pocket expenses incurred by a Participant. The type of expenses, and of Flexible Spending Accounts allowing for pre-tax payment, shall be as follows:

(a) Health Care. There is hereby created a self-insured "Medical Expense Reimbursement Plan" within the meaning of Code Section 105(h). The purpose of the Medical Expense Reimbursement Plan is to provide Participants with non-taxable reimbursements of Qualifying Medical Care Expenses.

(b) Dependent Care. There is hereby created a "Dependent Care Assistance Program" within the meaning of Code Section 129. The purpose of the Dependent Care Assistance Program is to provide Participants with non-taxable reimbursements of Qualifying Dependent Care Expenses.

5.2 Establishment of Accounts. For each Participant, the Administrator shall establish and maintain on its books an Account for each Flexible Spending Account Plan under which benefits have been elected for the Period of Coverage. Any such Account is for record-keeping purposes only and does not involve any actual segregation of assets.

5.3 Crediting of Accounts.

(a) Medical Expense Reimbursement Account. As of the beginning of each Period of Coverage, there shall be credited to a Participant’s Account an amount equal to the amount of benefits he or she elected for that Period of Coverage under the Medical Expense Reimbursement Plan.

(b) Other Accounts. For each Period of Coverage, there shall be credited to a Participant’s Account under the Dependent Care Assistance Program, as of each date Compensation is paid to the Participant in such Period of Coverage, an amount equal to the reductions made in such Compensation pursuant to his or her election under those Flexible Spending Account Plans for the Period of Coverage.

5.4 Maximum Electable Benefit Amounts. The maximum (and minimum, where applicable) amount of benefits that a Participant may elect on his or her election form under the Flexible Spending Account Plans is as follows:

(a) Medical Expense Reimbursement Plan: $3,000 maximum

(b) Dependent Care Assistance Program: The legal limit applicable to the Participant, as described in Section 5.5 below, multiplied by the number of calendar years fully or partially included in the Plan Year.

5.5 Code Limits on Dependent Care Assistance. The maximum amount that a Participant may receive for reimbursement of Qualifying Dependent Care Expenses in any calendar year shall be the least of (a) the Participant’s earned income for the calendar year (after all reductions in compensation including the reduction related to dependent care assistance), (b) the actual or deemed earned income of the Participant’s spouse for the calendar year, if the Participant is married, or (c) $5,000 (or, if the Participant does not certify to the Administrator’s satisfaction that he or she is either unmarried or will file a joint Federal income tax return for the year, $2,500). In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Qualifying Individual and $500 per month if the Participant has two or more Qualifying Individuals. In the case of two Participants who are married to each other and who file a joint Federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the year under this Plan by the Participant’s spouse. For
purposes of this Section 5.5, "earned income" shall have the meaning given it by Section 32(c)(2) of the Code, and a Participant shall not be treated as married if the Participant is not considered as married under the special rules of Code Section 21(e)(3) and (4).

5.6 **Debting of Accounts.** A Participant's Account under a Flexible Spending Account Plan shall be debited from time to time in the amount of any payment to or for the benefit of the Participant under the terms of that Plan during the Period of Coverage.

5.7 **Claims for Reimbursement.** A Participant may apply to the Administrator for reimbursement of a Qualifying Expense incurred by the Participant during a Period of Coverage by submitting an application in writing to the Administrator, in such form as the Administrator may prescribe, setting forth the information described in this Section.

   (a) **Generally Applicable Required Information.** Any claim application shall include:

   (1) the amount, date and nature of each expense with respect to which a benefit is requested;

   (2) the name of the person, organization or entity to which the expense was or is to be paid;

   (3) the name of the person for whom the expense was incurred and the relationship of such person to the Participant; and

   (4) such other information as the Administrator may from time to time require.

   (b) **Medical Expense Reimbursement Claims.** A Participant also shall include in any application for reimbursement of a claim from his or her Medical Expense Reimbursement Account a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

   (c) **Dependent Care Assistance Claims.** A Participant also shall include in any application for reimbursement of a claim from his or her Dependent Care Assistance Account (i) the name, address and taxpayer identification number of the person performing the services; or (ii) if such person is an organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a), the name and address of such person (unless a Participant failing to provide such information can show that due diligence was exercised in attempting to obtain it).

   (d) **Accompanying Documentation.** Any claim application shall be accompanied by bills, invoices, receipts, or other statements or certifications showing the amounts of the expenses incurred, together with any additional documentation which the Administrator may request. An application may be made before or after the Participant has paid a Qualifying Expense, but not before the Participant has incurred such Qualifying Expense.

5.8 **When an Expense is Incurred.** A Qualifying Expense shall be deemed incurred at the time the services giving rise to the Expense are rendered.

5.9 **Direct Payment Option.** The Administrator may, at its option, pay any Qualifying Expense directly to the person providing or supplying the services that gave rise to the Expense, lieu of reimbursing the Participant.

5.10 **Amount Available For Payment of Claims.**

   (a) **Medical Expense Reimbursement Claims.** The amount available to reimburse a Participant for claims for Qualifying Medical Care Expenses shall, at all times during a Period of Coverage, be equal to the amount of benefits the Participant elected to receive under the Medical Expense Reimbursement Plan for that
Period of Coverage, less any previous reimbursements made to the Participant for such Expenses incurred within that Period of Coverage.

(b) Other Flexible Spending Account Claims. Except as provided in "(a)" above, no reimbursement of Qualifying Expenses incurred during a Period of Coverage shall exceed the balance of the Participant's Account under the Flexible Spending Account Plan from which such Expenses otherwise may be made. The amount of any Qualifying Expenses not reimbursed as a result of the preceding sentence shall be carried over and reimbursed only if and when the balance in the Participant's Account permits such reimbursement.

5.11 Deadline for Claims Submission. Any claim for reimbursement of a Qualifying Expense must be submitted to the Administrator by no later than the ninetieth day following the last day of the Plan Year within which ended the Period of Coverage during which the Qualifying Expense was incurred. The Administrator shall not pay any claim submitted after that date.

5.12 Code Limitations on Reimbursements to Certain Participants.

(a) Nondiscriminatory Benefits. Each of the Flexible Spending Account Plans is intended not to discriminate as to eligibility to participate or benefits in favor of highly compensated individuals or highly compensated employees, as the case may be as those terms are defined in the applicable provisions of the Code. If, in the judgment of the Administrator, the operation of the Plan in any Plan Year would result in such discrimination, the Administrator may take such remedial action as the Administrator deems necessary or appropriate to assure that the Plan does not discriminate, including but not limited to, restricting the amounts reimbursed to such persons or excluding such persons altogether from participation. Such remedial actions may be taken whether or not to do so would result in a forfeiture of any Account balance.

(b) Dependent Care Assistance Program. The following rules shall apply to the operation of the Dependent Care Assistance Program:

1. Not more that twenty-five percent of the total amount reimbursed under the Dependent Care Assistance Program during any Plan Year may be reimbursed with respect to Participants who own more than five percent of the stock or of the capital or profits interest of the Employer (or their spouses or Dependents).

2. The average benefits provided to Participants who are not highly compensated employees must be at least fifty-five of the average benefits provided to highly compensated employees (within the meaning of Code Section 414(q)) under all dependent care assistance plans of the Employer. For purposes of this limitation, in the case of any benefits provided through a salary reduction agreement, any Participant whose compensation is less than $25,000 may be disregarded. Also, for the purposes of the foregoing, there shall be excluded from consideration employees who are described in Code Section 129(d)(9).

5.13 Forfeiture of Unused Account Balances. If any balance remains in a Participant's Flexible Spending Account for a Period of Coverage after all authorized reimbursements have been made, such balance shall not be carried over to reimburse the Participant for Qualifying Expenses incurred during a subsequent Period of Coverage and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with respect to such balance. The Employer may use any forfeited account balances to pay any administrative expenses of the Plan or in any other manner that does not violate any applicable law or regulation. For this purpose, "administrative expense" shall include any amount by which the benefits paid to any Participant under the Medical Expense Reimbursement Plan for any Period of Coverage exceeded the Participant's contributions to the Medical Expense Reimbursement Plan for that Period of Coverage.
5.14 **Inactive Participant Status.** Except as hereinafter provided, an individual shall become cease being a Participant in a Flexible Spending Account Plan and become an Inactive Participant in that Flexible Spending Account Plan when he or she ceases to be a Participant pursuant to Section 3.2 or when his or her election for benefits under that Flexible Spending Account Plan expires, whichever first occurs. An individual who has the status of Inactive Participant with respect to any Flexible Spending Account Plan may submit further claims for reimbursement of Qualifying Expenses under that Flexible Spending Account Plan only in accordance with the following:

(a) An Inactive Participant in the Medical Expense Reimbursement Plan may submit claims for any Qualifying Medical Care Expenses incurred during the Period of Coverage ending on the date he or she becomes an Inactive Participant, until the ninetieth day following the last day of the Plan Year within which that Period of Coverage ends.

(b) An Inactive Participant in any other Flexible Spending Account Plan may submit claims for any Qualifying Expenses reimbursable under that Flexible Spending Account Plan incurred at any time during the Plan Year within which he or she becomes an Inactive Participant, until the ninetieth day following the last day of that Plan Year.

5.15 **Continuation Coverage under the Medical Expense Reimbursement Plan.**

(a) **Continuation Coverage under COBRA.** A Participant who is covered by a "group health plan", within the meaning of Code Section 4980B (a "Group Health Plan"), and any spouse or Dependents of the Participant who also are covered by that Group Health Plan, may be entitled to elect to continue coverage that otherwise would terminate, according to the rules of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA"). The right to COBRA continuation coverage under any Insurance Plan is as set forth in the documents pursuant to which that Insurance Plan is maintained. The purpose of this Subsection is to describe the COBRA continuation rights of persons losing coverage under the Medical Expense Reimbursement Plan.

COBRA continuation coverage shall be available only if a Participant, a Participant's spouse or a Participant's Dependent experiences a Qualifying Event at a time when there is a positive balance in the Medical Expense Reimbursement Account covering such person. For this purpose, "Qualified Event" means:

1. termination of the Participant's employment or reduction of the Participant's work hours (Note: If a Participant fails to return to active employment following an FMLA leave of absence, the Qualifying Event of termination of employment occurs at the earlier of the end of the leave or the date that the Employer is notified that will the Participant will not be returning);

2. the death of the Participant;

3. the divorce or legal separation of the Participant from his or her spouse;

4. the Participant's eligibility for Medicare benefits;

5. the cessation of dependent status of any Dependent; and

6. the bankruptcy of the Employer.

A Medical Expense Reimbursement Account has a positive account balance as of the date of a Qualifying Event if the total contributions to the Account for the Period of Coverage ending on that date is greater than the total reimbursements from the Account for that Period of Coverage (including for this purpose, any claims that have been submitted but not paid).
A Participant experiencing a Qualified Event described in (2), (3) or (4) above must notify the Administrator within sixty days after it occurs. The Administrator then shall provide to the Participant and the spouse of the Participant, if any, a notice describing the options available for continuing coverage under the Medical Expense Reimbursement Plan at specified premium costs. The coverage available shall be the individual's coverage under that Plan on the date immediately preceding the Qualifying Event.

An individual who elects COBRA continuation coverage and pays the applicable premiums for the periods of coverage elected shall have the right to reimbursement of additional claims incurred only during the remainder of the Plan Year within which the Qualifying Event occurred. Provided, however, continuation coverage shall sooner end upon any of the following events: the termination by the Employer of the Medical Expense Reimbursement Plan; the covered individual's failure to pay a required premium within thirty days after its due date; the commencement of coverage under another group health plan that does not include a preexisting conditions clause or under Medicare; or, if the individual had been determined to be disabled, the date he or she is determined by the Social Security Administration to no longer be disabled.

(b) *Continuation Coverage under USERRA.* If a Participant takes a leave of absence from the Employer in connection with duty in the uniformed services, the Uniformed Services Employment and Reemployment Act ("USERRA") requires that he or she shall continue to be covered under a Group Health Plan as an active employee during the first thirty one days of the leave only. Should such leave extend beyond thirty-one days, the Participant's coverage under the Group Health Plan as an active employee shall terminate. However, the Participant may elect COBRA Continuation Coverage under the plan at his or her own expense in accordance with "(a)" above. For the foregoing purposes, "uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

**ARTICLE VI: ADMINISTRATION OF PLAN**

6.1 *Plan Administrator.* The Administrator shall administer the Plan in accordance with its terms without discriminating among the Participants. The Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(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 persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering 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 of the Insurance Plans shall not be subject to review under this Plan, and the Administrator's authority under this Section 6.1 shall not extend to
any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

6.2 Examination of Records. The Administrator shall make available to each Participant such of his records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

6.3 Reliance on Tables, etc. In administering the Plan, the 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 Component Plans, or by accountants, counsel or other experts employed or engaged by the Administrator.

6.4 Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by an act or omission to act in connection with the Plan, if such act or omission is in good faith and was not the product of gross negligence.
ARTICLE VII: CLAIMS

7.1 Scope of Claims Review under this Plan. Except to the extent otherwise specifically provided herein, any claim for benefits under an Insurance Plan shall be governed by the claims procedures that are included in the plan documents pursuant to which that Plan is maintained. The claims procedures in this Article shall apply to (i) any partial or total denial of benefits under any Flexible Spending Account Plan, and (ii) any denial of benefits due to an issue germane to the claimant's coverage under the Flexible Spending Account Plan (e.g., whether an Eligible Employee has satisfied any Minimum Service Requirement or whether a Change in Status has occurred).

7.2 Claims Procedure.

(a) Any person who believes that he is entitled to a benefit shall have the right to file with the Administrator a written notice of claim for such benefit. The Administrator shall either grant or deny such claim within thirty days after the receipt of such written notice of claim (or within such other period as may be mutually agreed to by the parties). Provided, however, if circumstances beyond its control so dictate, the Administrator may extend that time by a maximum of fifteen days by giving the claimant written notice of such extension within the initial thirty-day period. Such notice shall identify the reason for the extension and the date by which the Administrator expects to make its decision. If the reason is a lack of complete information, the notice shall identify the additional information needed, shall grant the claimant forty five days from the date of the extension notice to furnish that information, and further shall advise the claimant that the tolling of the limitation period for the Administrator's response shall be suspended until the Administrator receives the information. Any delay on the part of the Administrator in arriving at a decision shall not adversely affect benefits payable under a granted claim. The failure to pay interest on the value of a Participant's Account during the processing of a claim shall not be deemed to be an adverse effect attributable to Administrator delay.

(b) In the case of a denied claim, the Administrator shall provide written notice to the claimant setting forth:

(1) The specific reason for such denial;

(2) Specific reference to the pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) An explanation of the Plan's claim review procedures set forth in Section 7.3 of the Plan.

7.3 Review of Denied Claim.

(a) Any person whose claim is denied may appeal in writing to the Administrator at any time within one hundred eighty days after the claimant receives written notice of such denial. The appeal should include the reason or reasons the claimant believes the Administrator's claim denial to have been in error. In the event of such appeal, the Administrator shall afford the claimant or his duly authorized representative the opportunity:

(1) To review documents pertinent to the claim;

(2) To submit issues and comments in writing; and

(3) To discuss such documents and issues with the Administrator.
(b) The final decision of the Administrator shall be made not later than sixty days after its receipt from the claimant of a request for review, unless there are special circumstances, such as the need to hold a hearing, or an extension of time for processing, in which case a decision shall be made as soon as possible but not later than one hundred twenty days after receipt of a request for review. If the decision on appeal affirms the initial denial, the claimant shall be furnished with a written notice to that effect that shall include the following:

(1) the specific reasons for decision on appeal;

(2) the specific Plan provisions on which the decision is based;

(3) statement of the right to review, upon request and at no charge, such Plan documents as the claimant shall deem relevant;

(4) a description of any internal rule, guideline, protocol or similar criterion that was relied on in reaching the decision and a statement that a copy of same is available upon request and at no charge;

(5) a statement of the claimant's right to initiate legal action, if applicable.
ARTICLE VIII: AMENDMENT AND TERMINATION OF PLAN

The Plan may at any time be amended or terminated by:

(a) If the Employer is a corporation, an action of the Board of Directors of the Employer (or an equivalent governing body) or a written instrument executed by the President of the Employer.

(b) If the Employer is a partnership, a written instrument executed by the Managing Partner.

(c) If the Employer is a sole proprietorship, by the owner of the Employer.

ARTICLE IX: MISCELLANEOUS PROVISIONS

9.1 Information to be Furnished. Participants shall provide the Employer and 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 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein.

9.3 Benefits Solely From General Assets. Except as may otherwise be required by law:

(a) Any amount by which a Participant's Compensation is reduced under this Plan will remain part of the general assets of the Employer;

(b) Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

(c) No Participant or other person shall have any claim against, right to or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

9.4 Use and Disclosure of Protected Health Information. This Plan (and its agents) will use information that is "protected health information" ("PHI") for purposes of the privacy rules issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") only as permitted by HIPAA. Specifically, the Plan will and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations as defined under HIPAA.

The Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Plan documents have been amended to provide that the Employer will:

(a) Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer regarding the use and disclosure of PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
(d) Not use or disclose protected health information in connection with any of the Employer's other benefit plans unless authorized by an individual;

(e) Report to the Plan any use or disclosure of PHI that the Employer becomes aware of;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures; make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA; and

(i) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which it disclosure was made (or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

In accordance with HIPAA, only those employees designated by the Employer shall be given access to PHI. You will be notified by your Employer from time to time as to who those employees are. Those employees may use and disclose PHI only for Plan Administration functions that the Employer performs with respect to the Plan. The Employer shall provide a mechanism for resolving issues of noncompliance (i.e., allegations that authorized employees have failed to comply with this Section 9.4), including disciplinary sanctions.

9.5 **Governing Law.** This Plan shall be construed, administered and enforced according to the laws of the State wherein the principal office or place of business of the Employer is located.

9.6 **Complete Document.** This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Employer document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions, and the remainder of the Plan document shall continue in full force and effect.

**IN WITNESS WHEREOF,** the Employer has caused this Plan to be executed in its name and on its behalf as of January 1, 2005.

**ST. JOHN'S UNIVERSITY**

By: ________________________________
ST. JOHN’S UNIVERSITY
FLEXIBLE BENEFITS PLAN

PLAN SUMMARY
ST. JOHN'S UNIVERSITY
FLEXIBLE BENEFITS PLAN
PLAN SUMMARY

St. John’s University maintains the St. John’s University Flexible Benefits Plan (the "Plan") for the benefit of its eligible employees. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.
IDENTIFYING INFORMATION

1. Plan Name and Number:

St. John’s University Flexible Benefits Plan; Plan Number 501.

2. Employer Name, Address and Identification Number:

St. John’s University
8000 Utopia Parkway
Jamaica, NY 11439

11-1630830

3. Plan Administrator and Agent for Service for Process:

St. John’s University
8000 Utopia Parkway
Jamaica, NY 11439

(718) 990-6587

4. Claims Administrator:

Your Employer has retained P & A Administrative Services, Inc. to assist in Plan Administration. All claim forms should be submitted to:

P & A ADMINISTRATIVE SERVICES, INC.
17 Court Street - Suite 500
Buffalo, New York 14202

5. Plan Year-End: December 31
THE FLEXIBLE BENEFITS PLAN

OVERVIEW

The Plan gives you the opportunity to avoid taxes on money that you spend on certain expenses, many of them commonly occurring. The expenses that you may pay under the Plan are: your share of the cost of insurance coverage you receive through the Employer; health care expenses that are not covered by insurance; and expenses for the care of your children or other dependents so that you are able to work. So that you and other eligible employees can enjoy the tax savings the Plan is intended to provide, the Plan is operated according to certain rules contained in the federal tax laws and regulations.

If you want to take advantage of the tax savings potential that the Plan offers, you will need to figure out the types and amounts of covered expenses that you will have each year. Then, you will need to complete an election form based on your determination. When you complete an election form, you will instruct the Employer to withhold enough money from your pay to cover your anticipated expenses. The monies withheld will be set aside to pay these expenses in the manner described below.

Unless you file an election with the Plan Administrator to the contrary (on a form available from the Administrator), you will be treated as having elected to have your compensation reduced to the extent necessary to pay through the Plan your share of the cost of the employer-sponsored insurance coverage you are receiving.

The following is a list of some of the more commonly asked questions regarding your Plan.

PLAN

The formal name of the Plan is the St. John’s University Flexible Benefits Plan.

PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The Plan was most recently updated as of January 1, 2005.

WHAT IS THE PLAN YEAR?

Plan Year means each 12-month period from January 1 through December 31.
ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

To be eligible for the Plan, you must be regularly scheduled to work at least 35 hours a week for the Employer, and you may not be classified by the Employer as a part-time employee. If you are an eligible employee, you will qualify for pre-tax benefits under the Plan by becoming a Plan “Participant” on the first day of the month after you start working for the Employer. However, if you start work on the first day of a month, you will become a Participant on that same date.

HOW DO I PARTICIPATE?

When you become a Participant in the Flexible Benefits Plan, you will receive a form that you can use to elect the benefit options under the Plan that you desire.

PLAN CONTRIBUTIONS

HOW ARE BENEFITS PAID FOR?

You pay for your own benefits under the Plan with money that is withheld from your pay based on your election form. The Employer will credit your salary withholdings to you and will draw upon them to pay for the benefits that you have elected under the Plan. Your salary reductions under the Plan are not included in your pay for federal income tax or Social Security tax purposes (although the New Jersey state income tax applies to any salary reductions that you elect if you are a New Jersey taxpayer). As such, the Plan enables you to use untaxed dollars to pay for benefits and expenses that would otherwise have to be paid with fully taxable, out-of-pocket dollars.

WHEN ARE CONTRIBUTIONS MADE TO THE PLAN?

Unless the Employer tells you otherwise, your salary reduction contributions to the Plan will be withheld from your pay each pay period on a pro rata basis over the course of the Plan Year.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED BY MY CONTRIBUTIONS TO THE PLAN?

Your Social Security benefits may be slightly reduced because, when you reduce your compensation to pay for expenses that are covered by the Plan, the amount of contributions that are made to the federal Social Security system to provide you Social Security benefits also are reduced.
PLAN BENEFITS

WHAT BENEFITS MAY I CHOOSE UNDER THIS PLAN?

The benefits under the Plan consist of the various categories of expenses that you may elect to pay for on a non-taxable basis, using your salary withholdings. If you want to pay for your share of the cost of insurance coverage you receive from the Employer through the Plan, elect the Insurance Premium Pre-Tax Payment Option described below; if you want to pay for your uninsured health care expenses through the Plan, elect the Medical Expense Reimbursement Plan option described below; and if you want to pay for day care costs through the Plan, elect the Dependent Care Assistance Program option described below.

If you elect benefits under the Medical Expense Reimbursement Plan or the Dependent Care Assistance Program (collectively, the “Reimbursement Account Plans”), your contributions to pay for your expenses covered by that option will be credited to an account in your name. This “Account” is for record-keeping purposes only and does not involve any actual segregation of funds.

WHAT BENEFITS ARE AVAILABLE UNDER THE INSURANCE PREMIUM PRE-TAX PAYMENT OPTION?

You may elect under the Insurance Premium Pre-Tax Payment Option to have premiums for coverage under the medical, dental, disability income and term life insurance plans of the Employer paid from your salary reductions. The portion of the premiums for that coverage that you elect to pay through salary reduction is deducted from your gross pay, thereby reducing your federal taxable income.

Unless and until you file an election with the Plan Administrator to the contrary (on a form provided to you by the Plan Administrator), you will be treated as having elected to have your compensation reduced to the extent necessary to pay through the Plan your share of the cost of any insurance coverage you are receiving through the Employer on a pre-tax basis.

WHAT BENEFITS ARE AVAILABLE UNDER THE MEDICAL EXPENSE REIMBURSEMENT PLAN?

If you elect the Medical Expense Reimbursement Plan option, you will be reimbursed for medical expenses not covered or paid for by insurance plus expenses incurred from medical care for yourself, your spouse or dependents which are not covered or paid for under any other plan or policy. "Medical care" includes care for the diagnosis, cure, treatment or prevention of disease. Expenses for medical care include expenses for routine and extraordinary medical and dental examinations, vision exams and eye-wear, surgery, psychiatric care, hospitalization, prescription and over-the-counter drugs and medicines, therapeutic, orthopedic and prosthetic aids and devices, and transportation primarily for essential medical care.

You may elect to pay up to $3,000 in covered expenses through this Medical Expense Reimbursement Plan option.
WHAT BENEFITS ARE AVAILABLE UNDER THE DEPENDENT CARE ASSISTANCE PROGRAM?

If you select the Dependent Care Assistance Program option, you will be reimbursed for your qualified dependent care expenses. Under the Plan, you will be reimbursed only for dependent care expenses that meet all the following conditions:

1. The Expenses were incurred for services rendered after the date you became a Participant.

2. Each individual for whom you incur the expense:
   (a) is either (i) a dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return or (ii) a spouse or other dependent for tax purposes who is physically or mentally incapable of caring for himself or herself.
   (b) lived with you for most of the calendar year; and
   (c) if the individual is a disabled adult who is not your spouse (e.g. your parent or your grandparent), he or she did not have gross income for the calendar year that was more than the amount of the personal exemption deduction under federal tax law for that year ($3,200 in 2004)

3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

5. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

WHAT EFFECT WILL PARTICIPATION IN THE DEPENDENT CARE ASSISTANCE PROGRAM HAVE ON MY RIGHT TO THE DEPENDENT CARE CREDIT ON MY TAX RETURN?

To the extent you use your reimbursement account to pay for dependent care expenses, you cannot use the Federal dependent care credit when you file your income tax return. The dollar amount of expenses eligible for the dependent care credit must be reduced, dollar for dollar, by the amount of expenses excluded from income through spending accounts. For some people the tax credit may be more favorable than the reimbursement account. In other situations, the reimbursement account will be more favorable. Therefore, before deciding to use a reimbursement account for dependent care, you should determine which is more favorable for you.
ARE THERE ANY LIMITS ON THE AMOUNT THAT MAY BE EXCLUDED FROM MY PAY FOR DEPENDENT CARE ASSISTANCE?

Yes. In general, the amount of expenses that you may pay through the Dependent Care Assistance option is limited to $5,000 per calendar year ($2,500 if you are a married but you and your spouse file separate tax returns). However, the amount of expenses can never exceed your earnings for the year or the earnings of your spouse, whichever is lower. Special rules apply in determining the earnings of a spouse who is a student or incapable of caring for himself or herself.

REIMBURSEMENT ACCOUNT CLAIMS

HOW DO I RECEIVE REIMBURSEMENT ACCOUNT BENEFITS?

If you elect benefits under the Medical Expense Reimbursement Plan or Dependent Care Assistance Program, the Administrator will issue you a debit card for you to use. Then, as you have eligible expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office, a pharmacy or a day care center). If the provider accepts the card, the provider will swipe the card in a manner similar to way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Plan's Claims Administrator, identified below, including the identity of the provider of the goods or services, the amount you paid, the date of your payment and the nature of the expense. If the information is not sufficient to verify that your payment was for an eligible expense, the Claims Administrator may request such additional documentation as it deems necessary.

You can also obtain reimbursement for expenses allowed under the Reimbursement Account Plans by submitting reimbursement claim forms and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date amount of the expense. A reimbursement claim form submitted under the Dependent Care Assistance Program must include the name, address and taxpayer identification number of the dependent care service provided. In the case of a babysitter, the taxpayer identification number is the babysitter's Social Security number. It is your responsibility to maintain adequate records to verify these expenses. You must apply for reimbursement on or before the 90th day following the close of the Plan Year. Upon receiving a properly completed reimbursement claim form accompanied by the appropriate documentation from you, the Administrator will distribute to you or your beneficiary the amount to which you are entitled.

The Employer has retained P & A Administrative Services, Inc. to process your claims. All claim forms should be submitted to:

P & A ADMINISTRATIVE SERVICES, INC.
17 Court Street - Suite 500
Buffalo, New York 14202

To insure timely reimbursement, please do not submit your claims to your Employer.
WHAT IS THE MAXIMUM AMOUNT I CAN RECEIVE?

If, for any Plan Year, you make an election under the Medical Expense Reimbursement Account option, the amount that you elect will be immediately credited to a Medical Expense Reimbursement Account in your name. Starting on the first day of that Plan Year, you will be entitled to be reimbursed for claims up to the entire elected amount (reduced by the amount of Medical Expense claim payments you already received for that year) at any time during the Plan Year, even if the total salary reduction contributions that you have made to your Medical Expense Reimbursement Account are less than the total amount of claims that you have submitted.

For claims under the Dependent Care Assistance Account option, the largest amount that you will be entitled to be reimbursed for at any point will be the amount that is in your Dependent Care Assistance Account at the time a claim is filed.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?

You will be notified in writing by the Plan Administrator within 30 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied and further advise you of what steps, if any, you may take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim. You may request a review any time within the 180-day period after you have received notice that the claim was denied. Your request for review must be in writing. You or your authorized representative will have the opportunity to review any important documents held by the Administrator and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for review.

WHAT HAPPENS TO MONEY LEFT IN MY REIMBURSEMENT ACCOUNT?

Any amounts in your Medical Expense Reimbursement Account or your Dependent Care Assistance Account at the end of the permissible reimbursement period for a Plan Year will be forfeited and used by the Employer to offset administrative expenses and future costs. Because your salary reduction contributions not used to reimburse you for expenses incurred in the Plan Year will be forfeited, it is important that you carefully determined the proper amount of your compensation to allocate to each account.

MID-YEAR CHANGES

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

If you take a leave of absence from your employment with the Employer, your election for benefits under the Plan will remain in effect if your compensation from the Employer will continue to be paid during that leave. If, on the other hand, your leave is unpaid, you will have the opportunity, before the leave starts, to revoke your election and, if desired, make a new election in accordance with the rules discussed below at the Section entitled, "May I Change My Benefit Election?"

If you take a leave of absence to which the Family Medical Leave Act of 1993 ("FMLA") applies, during the period of such leave you will have the option of continuing your coverage under the Employer’s medical
insurance plan and Medical Expense Reimbursement Plan on the same terms and conditions as though you were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent you elect to continue you coverage). You may do so by either paying your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or by prepaying all or a portion of your share of the premium for the anticipated duration of the leave on a pre-tax salary reduction out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreeable to the Administrator. Upon return from FMLA leave, you will be permitted to reenter the Plan on the same basis on which you were participating prior to taking leave.

MAY I CHANGE MY BENEFIT ELECTION?

While you may change your election before the beginning of a new Plan Year, as a rule, you may not change an election of benefits during the Plan Year. However, if you experience any of the following events, you may revoke your election after the Plan Year has commenced and make a new election for the balance of the Plan Year:

1. *Change in Status.*

(a) A change in your legal status (e.g., marriage, death of your spouse, divorce, legal separation or annulment).

(b) A change in the number of your dependents due to events such as birth, adoption, placement for adoption or death.

(c) A termination or commencement of employment by your spouse or dependent.

(d) A reduction or increase in the hours that you, your spouse or your dependent work, including a switch between part-time and full-time status and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or of any other employee benefit plan that you, your spouse or your dependent depend on the employment status of the individual and a change in that individual’s employment status causes that individual either to become eligible or cease to be eligible under the plan, that change constitutes a Change in Status.

(e) An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for a certain benefit (e.g., due to attainment of a certain age).

(f) A change in the place where you, your spouse or your dependent work or reside.

If you wish to change your election based on a Change in Status, the change must be consistent with that Change in Status, under the following rules:

Your change of election will be considered to be consistent with a Change in Status only if the Change in Status results in you, your spouse or your dependent gaining or losing eligibility for a benefit (or particular benefit option) under a plan of the Employer or under a plan of your
spouse's or dependent's employer, and the change of election corresponds with that gain or loss of coverage, or, if the Change in Status affects dependent care expenses described in Code Section 129.

If the Change of Status is your divorce, annulment or legal separation, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, your election under the Plan to cancel accident or health coverage for any individual other than your spouse involved in the divorce, annulment or legal separation, your deceased spouse or dependent or the dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, fails to correspond with that Change in Status. In addition, if you or your spouse or dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are nontaxable benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes available or is increased under the plan from which eligibility for coverage has been gained. Provided, however, any election to change disability income or term life insurance coverage may be deemed to correspond with a Change of Status whether it involves a decrease in the amount of coverage or an increase in the amount of coverage.

If you or your spouse or dependent become eligible for COBRA continuation coverage, you may elect to increase payments under this Plan to pay for that coverage.

2. Special Enrollment Rights. You, your spouse and/or your dependent may change your election for the balance of the Plan Year and file a new election that corresponds with any special enrollment rights you may have under a group health plan.

3. Certain Judgments and Orders. If a judgment, decree or order from a divorce, legal separation, annulment or custody change requires that your child, or a foster child who is your dependent, be covered under the Employer's health plan or the health plan of your former spouse's employer, you may change your election to provide coverage for the child under the Employer's plan if the order requires it or change your election to cancel coverage for the child under the Employer's plan if the order requires your spouse or former spouse, or any other individual, to provide the coverage.

4. Entitlement to Medicare or Medicaid. If you, your spouse or your dependent becomes entitled to coverage under Medicare or Medicaid, you may cancel that person's accident or health coverage. In addition, if you or your spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for that coverage, you may make a prospective change of election to commence or to increase that person's coverage under the accident or health plan.

5. Change in Cost or Coverage. A change of cost or change of coverage with respect to non-cash benefits that may be elected under this Plan may be the basis for a change of election based on the following rules:

(a) These rules do not apply to benefits under the Medical Expense Reimbursement Plan.

(b) If the cost of any of your benefits increases or decreases during a period of coverage and, as a result, you are required to increase or decrease your payments for those benefits, your
salary reductions contributions under this Plan will be adjusted accordingly, unless you make a change to your election under (c) below.

(c) If the cost of any of your benefits significantly increases during a period of coverage, you may elect either to increase your contributions to pay for the increased cost or to revoke your election and to receive instead coverage under another benefit option of the plan providing the benefits. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which you have not elected that benefit or benefit option, you may make a new election of that type of benefit or benefit option. If you have an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, you may revoke that existing election and elect the benefit option that has significantly decreased in cost.

(d) You may only change your election due to an increase in the cost of dependent care assistance benefits if your dependent care provider is not your relative.

(e) If your coverage under any benefit plan is significantly reduced or stops, you may make a new election going forward of any other coverage option available under that plan. Coverage under an accident or health plan is considered to be reduced only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(f) You may make an election change that is on account of and corresponds with a change made under a benefit plan of your spouse, former spouse or dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules and if that plan permits participants to make an election for a period of coverage under the cafeteria or other plan that is different than that under this Plan.

6. Changes in Coverage Attributable to Spouse’s Employment. If there has been a significant change in your health coverage or your spouse’s health coverage attributable to your spouse’s employment, you may change your election in a manner that is consistent with that change in coverage.

Even if you are permitted to change your election under these rules, you may not change your election for Medical Expense Reimbursement or Dependent Care Assistance benefits below the amount of such benefits already reimbursed for the Plan Year.

IMPORTANT NOTE: Remember, unless you experience one of the limited circumstances allowing for election changes during the Plan Year, you will not be able to reduce or increase the amounts designated on your enrollment form, nor will you be able to change amounts from one account to another. This is why you are encouraged to plan carefully before you enroll in this Plan.

The Administrator must be notified within 30 days of any such event to make a change.

If you fail to submit a new election form for any new Plan Year, your election the Insurance Premium Pre-Tax Payment Option will remain the same as for the prior year, but you will be considered not to have elected any benefits under the Medical Expense Reimbursement Plan or Dependent Care Assistance Program options for the new year.
MAY MY ELECTION BE CHANGED WITHOUT MY CONSENT?

If the Plan Administrator determined before or during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Internal Revenue Code, the Administrator may take action to assure compliance with any requirements or limitations. This action may include a modification of any elections with or without the consent of the Employee.

WHAT HAPPENS IF I STOP WORKING FOR THE EMPLOYER OR I BECOME INELIGIBLE FOR THE PLAN FOR ANOTHER REASON?

Subject to any rights you may have to continuation coverage as discussed below, you no longer will be eligible to participate in the Plan if you stop being regularly scheduled to work at least 35 hours a week for the Employer or if you become classified by the Employer as a part-time employee. This means that your contributions to the Plan will cease. However, you will be permitted to submit Medical Expense Reimbursement claims and Dependent Care Assistance claims for expenses that were incurred during the portion of the Plan Year prior to the date your eligibility terminated, until 60 days after that date. The amount available for reimbursement of Medical Expense Reimbursement claims will be the benefit amount you elected for the year (as adjusted for any mid-year election changes you were permitted to make), reduced by the amount of prior medical expense reimbursements for the year. The amount available for reimbursement of Dependent Care Assistance claims will be whatever amount remains in your Dependent Care Assistance Account at the time you lose eligibility.

CONTINUATION COVERAGE

ARE THERE ANY CIRCUMSTANCES UNDER WHICH I MAY CONTINUE TO RECEIVE COVERAGE AFTER MY EMPLOYMENT TERMINATES?

COBRA

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") may allow you (and your spouse and dependent children, if any) to continue group health coverage that otherwise would terminate. The right to COBRA continuation coverage under the Employer’s health insurance plans is described in the insurance contracts and documents used to maintain those plans. This section of the Summary described the COBRA rights of any individual who has lost the right to participate under the Plan under the Plan’s normal eligibility provision at a time when he or she has a Medical Expense Reimbursement Account.

Subject to a limited exception, COBRA continuation coverage will be offered only if you, your spouse or your dependent experiences a Qualifying Event at a time when there is a positive balance in your Medical Expense Reimbursement Account. A "Qualified Event" occurs only if:

1. your employment with the Employer terminates or your work hours are reduced (Note: If you fail to return to active employment following an FMLA leave of absence, you experience a qualifying event at the earlier of the end of the leave or the date that the Employer is notified that you will not be returning);

2. you die;
3. you become divorced or legally separated from your spouse;

4. you become eligible for Medicare benefits;

5. a dependent of yours loses dependency status; or

6. your Employer becomes the subject of a bankruptcy petition.

Your Medical Expense Reimbursement Account will have a positive account balance at the time a Qualifying Event occurs if the total contributions to the Account for the Period of Coverage ending on that date is greater than the total reimbursements from the Account for that Period of Coverage ending on that date is greater than the total reimbursements from the Account for that Period of Coverage (including for this purpose, any claims that have been submitted but not paid).

If you experience a qualifying event described in 2, 3 or 4 above you must notify the Administrator within sixty days after it occurs. The Administrator then will provide you and your spouse, if any, with a notice describing the options available for continuing coverage under the Medical Expense Reimbursement Plan at specified premium costs. The coverage available will be your coverage under that Plan on the date immediately preceding the Qualifying Event.

If you elect COBRA continuation coverage and pay the applicable premium, you will have the right to reimbursement of additional claims incurred during the rest of the Plan Year within which the Qualifying Event occurred. However, continuation coverage will end upon any of the following events: on the date your Employer terminates the Medical Expense Reimbursement Plan; you fail to pay a required premium within thirty days after its due date; the coverage for you starts under another group health plan that does not include a preexisting conditions clause or under Medicare; or, if you have been determined to be disabled, on the date you are determined by the Social Security Administration to no longer be disabled.

**USERRA**

A federal law known as "USERRA" may require that Participants who cease to be eligible to receive health care coverage because of duty in the uniformed services be given the right to buy continued health coverage on an after-tax basis. USERRA also requires that for Participants who perform service in the uniformed services for less than 31 days, the Employer may not require the Participant to pay more than his or her share, if any, of the premium. With respect to non-health plans, USERRA requires that Participants be given the right to continue participation in the plan on the same basis as any Participant on a non-military leave of absence. To the extent required by applicable federal laws, the Administrator will implement and administer the procedures designed to comply with federal laws requiring the provision of continued coverage and plan participation and will give you notice of your rights under these laws.

**MISCELLANEOUS**

**CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?**

The Employer has the right at any time to amend in whole or in part any or all of the provisions of the Plan. However, no amendment may be passed which authorizes or permits any part of your account to be used or diverted for a purpose other than providing benefits to you and your beneficiaries.
The Employer also has the right at any time to terminate the Plan.

**WHO PAYS THE COSTS OF THE PLAN?**

The Employer pays the cost of administering the Plan.

**IS MY MEDICAL INFORMATION CONFIDENTIAL?**

P&A, as the Claims Administrator for the Plan, may come into possession of certain information about you and your family members that is considered "protected" under the HIPAA law. P&A will treat this information as confidential and will disclose this type of information only for the specific purposes of your health care treatment, paying for your health care and for "health care operations" as that term is defined under HIPAA.

P&A will disclose your protected health information to the Employer only after the Employer certifies that the Plan documents have been amended to provide that the Employer will:

1. Not use or disclose protected health information other than as permitted or required by the Plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Employer provides protected health information received from the P&A agree to the same restrictions and conditions that apply to the Employer regarding the use and disclosure of protected health information;

3. Not use or disclose protected health information for employment-related actions and decisions unless you have authorized it;

4. Not use or disclose protected health information in connection with any of the Employer's other benefit plans unless you have authorized it;

5. Report to P&A any use or disclosure of protected health information that the Employer becomes aware of;

6. Make your protected health information available to you according to HIPAA's access requirements;

7. Make protected health information available for amendment and incorporate any amendments to protected health information in accordance with HIPAA;

8. Make available the information required to provide an accounting of disclosures; make internal practices, books and records relating to the use and disclosure of protected health information received from P&A available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA; and

9. If possible, return or destroy all protected health information received from P&A that the Employer still maintains in any form, and retain no copies of that protected health information when no longer needed for the purpose for which it was disclosed (or, if return or destruction is
not possible, limit further uses and purposes that make it impossible to return or destroy the information).

In compliance with HIPAA, only a select group of employees are permitted to receive protected health information on behalf of your Employer. You will be notified by your Employer from time to time as to who those employees are. Any protected health information that these employees receive may be used only for purposes of administering this Plan. Your Employer will provide a mechanism for resolving issues regarding whether the designated individuals have violate the limitations that apply, including possible disciplinary sanctions.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN, THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.