



Hofstra University Flexible Spending Plan

Flexible Spending Plan
(Premium/Health/Dependent Care)
Amended and Restated Effective January 1, 2013

Hofstra University Flexible Spending Plan

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EXHIBIT A – CHANGE IN STATUS MATRIX

The Hofstra University Flexible Spending Plan

PREAMBLE

Effective September 1, 1989, Hofstra University established the Hofstra University Flexible Benefits Plan (the "Plan") to provide Eligible Employees with the opportunity to choose from among the Benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

Effective January 1, 2011 Hofstra University has amended and restated the Plan as set forth herein.

The Dependent Care Expense Reimbursement Plan is a component of this Plan which is intended to qualify as a Code Section 129 dependent care assistance plan. The Health Care Expense Reimbursement Plan is a component of this Plan which is intended to qualify as a Code Section 105 medical expense reimbursement plan.

ARTICLE I

DEFINITIONS

When used herein, the following words and phrases shall have the following meanings, unless the context clearly indicates otherwise.

1.1 **Annual Enrollment Election Period** means the period of time (to be determined each year by the Plan Administrator) each Plan Year during which an Eligible Employee makes (or is deemed to make) his or her contribution elections for the upcoming Plan Year.

1.2 **Benefit** means any of the benefits to which a Participant is entitled to under the Plan.

1.3 **Change in Status** means the events described in Exhibit A and any other events included under subsequent changes to Code Section 125 or regulations issued thereunder which the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis.

1.4 **Claims Administrator** means the person, firm or entity appointed by the Plan Administrator to process claims under the Plan.

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

1.6 **Compensation** means the total of all amounts paid to or accrued to the Eligible Employee as salary and wages for his or her services rendered for an Employer during the Plan Year, including amounts by which the Eligible Employee elects to reduce such salary and wages pursuant to the Plan and any other benefit plans sponsored by an Employer.

1.7 **Dependent** means (a) for purposes of accident or health coverage (to the extent funded under the Pre-Tax Premium Account, and for purposes of the Health Care Expense Reimbursement Account) ,(1) a dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code Section 152(f)(1) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or more both parents for more than half of the calendar year);

and (b) for purposes of the Dependent Care Account, a Qualifying Individual. Notwithstanding the foregoing, the Health Care Expense Reimbursement Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “Dependent”.

1.8 **Dependent Care Expense Reimbursement Account** means the individual dependent care account established by the Employer for each Participant for the purpose of accounting for contributions thereto and Benefits paid therefrom as reimbursement for eligible dependent care expenses.

1.9 **Dependent Care Expense Reimbursement Plan** means the Hofstra University Dependent Care Expense Reimbursement Plan as set forth in Section 6.4.

1.10 **Effective Date** means the date the Plan was established as provided in the Preamble. The Effective Date of this amendment and restatement of the Plan is January 1, 2004.

1.11 **Eligible Employee** means any employee of the Employer who is eligible to participate in the Plan as specified in Article III.

1.12 **Employer** means the Sponsor and each other entity that adopts the Plan with the written consent of the Sponsor.

1.13 **Employer-Sponsored Plan** means all indemnity, exclusive provider option (EPO), point of service (POS), health maintenance organization (HMO) or other medical or dental plans adopted by the Employer allowing for participation of active employees.

1.14 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

1.15 **Full-Time Student** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented. The individual must enroll for the number of hours or courses which is considered to be full-time attendance. School attendance exclusively at night does not constitute full-time attendance. However, full-time attendance at an educational institution may include some attendance at night in connection with a full-time course of study.

1.16 **Grace Period** means the 75-day period immediately following the close of the Plan Year during which a Participant may receive reimbursement out of any funds remaining in the Participant’s Health Care Expense Reimbursement Account or Dependent Care Expense Reimbursement Account as of the last day of the preceding Plan Year for reimbursable expenses incurred during the Grace Period.

1.17 **Health Care Expense Reimbursement Account** means the individual health care account established by the Employer for each Participant for the purpose of accounting for contributions thereto and Benefits paid therefrom as reimbursement for eligible health care expenses.

1.18 **Health Care Expense Reimbursement Plan** means the Hofstra University Health Care Expense Reimbursement Plan as set forth in Section 6.3.

1.19 **Participant** means any Eligible Employee who actually enrolls or who is deemed to enroll, and participates in the Plan.

1.20 **Plan** means this Hofstra University Flexible Spending Plan, together with any and all amendments and supplements thereto.

1.21 **Plan Administrator** means the person, firm or entity appointed by the Employer to manage and direct the operation of the Plan. If no such person, firm or entity is named; the Plan Administrator shall be the Employer.

1.22 **Plan Year** means the annual accounting period of the Plan, which shall begin on January 1 and end on December 31.

1.23 **Pre-tax Premium Account** means the individual premium account established by the Employer for each Participant for the purpose of accounting for contributions thereto and Benefits paid therefrom for Employer-Sponsored Plan premiums.

1.24 **Premiums** mean the Eligible Employee's costs for elected participation in the Employer-Sponsored Plans, as may be offered from time to time by the Employer.

1.25 **Qualified Benefit** means any benefit excluded from taxation under Chapter 1 of the Code (other than Section 117, 127 or 132), including any other benefit permitted by the Income Tax Regulations.

1.26 **Salary Redirection** means the amount by which an Eligible Employee elects to have his or her Compensation reduced in an amount sufficient to fund the Benefits such Eligible Employee has elected to receive under the Plan, subject to the terms, conditions and restrictions provided in the Plan.

1.27 **Salary Redirection Agreement** means an agreement by and between the Eligible Employee and his or her Employer entered into during the applicable Annual Enrollment Election Period whereby the Eligible Employee agrees to a reduction in Compensation for the purpose of purchasing Benefits and which for all purposes hereunder are deemed to be Employer contributions. A Participant will enter into such agreement by making an election, on a timely basis, in a manner prescribed by the Plan Administrator.

1.28 **Sponsor** means Hofstra University.

ARTICLE II

PURPOSE AND EFFECTIVE DATE OF THE PLAN

2.1 **Purpose**. The Plan is a welfare benefit plan under ERISA, and is intended to qualify as a nondiscriminatory salary reduction cafeteria plan under Sections 129, 125, 106, 105 and 79 of the Code. The Plan allows Eligible Employees the flexibility of choosing between certain Qualified Benefits through the Plan's Salary Redirection option or cash compensation. The Plan is further intended as an accident and health plan within the meaning of Section 105(e) of the Code and that reimbursements paid through the Health Care Expense Reimbursement Account are eligible for exclusion from Participant's income under Section 105(b) of the Code. Accordingly, the Plan shall be interpreted and construed in accordance with all such Sections of the Code and the regulations issued thereunder.

2.2 **Separate Plan Documents**. The Benefits offered under the Plan may be the subject of separate plan documents, agreements, policies and contracts and are incorporated herein by reference as the same may be changed from time to time. In the event of a conflict between the terms of the Plan and the terms of another plan contract or a particular insurer whose product is then being used in conjunction with the Plan, the terms of the other plan shall control as to those Participants receiving coverage under such other plan. For this purpose, the other plan shall control in defining the persons eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits the Participants are entitled to and the circumstances under which coverage terminates.

ARTICLE III

ELIGIBILITY FOR PARTICIPATION

3.1 **Eligible Employee**. Subject to the exclusions provided below, each individual having payroll status as an employee of the Employer who is regularly scheduled to work at least 20 hours per week is eligible to participate in the Plan. Employees covered by a collective bargaining agreement may not participate in the Plan

unless such agreement expressly provides for coverage under the Plan or an Employer-Sponsored Plan. Temporary Employees and Employees hired on a project basis are also not considered Eligible Employees.

3.2 **Eligibility Begins.** Eligibility to participate in the Health Care Expense Reimbursement Account, Dependent Care Expense Reimbursement Account and the Pre-tax Premium Account begins on the first day of the month following commencement of employment, unless such commencement occurs during the first four days of a calendar month, in which case eligibility shall begin immediately.

3.3 **Rehired Employee.** If a Participant terminates and resumes employment with the Employer within 30 days, the Participant's elections prior to termination of employment shall be reinstated, subject to any intervening change in status. If a Participant's employment ends and such Participant is rehired more than 30 days from termination date and prior to the end of the same Plan Year, the Participant shall return to the elections prior to termination of employment if the Participant does not make new elections. If a former Participant is rehired by the Employer in a Plan Year other than the Plan Year during which the former Participant's employment with the Employer ended, such former Participant is eligible to participate in the Plan in the same manner as any new employee.

3.4 **Unpaid Leave of Absence.**

(a) **Qualifying Leave under Family Leave Act.** Notwithstanding any provision to the contrary in this 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 the FMLA, the Employer will continue to maintain the Participant's medical coverage (as defined in Code §5000) on the same terms and conditions as though he were still an active Eligible Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Eligible Employee opts to continue his coverage). If such Participant opts to continue his coverage, the Participant may pay his share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Participant may be given the option to pre-pay all or a portion of his share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave Compensation by making a special election to that effect prior to the date such Compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next Plan Year), or via other arrangements agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold amounts upon the Participant's return). Upon return from such leave, the Participant will be permitted to reenter the Plan on the same basis the Participant was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

(b) **Non-FMLA Leave.** If a Participant goes on an unpaid non-FMLA leave of absence that does not affect eligibility under this Plan or an Employer-Sponsored Plan, then the Participant may continue to participate, and the contribution due may be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid non-FMLA leave of absence that affects eligibility under this Plan or an Employer-Sponsored Plan, the election change rules of Section 5.9 shall apply. The Plan Administrator shall have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility under this Plan or an Employer-Sponsored Plan.

ARTICLE IV

SALARY REDIRECTIONS

4.1 **Salary Redirections.** Participation in the Plan occurs through Salary Redirections made pursuant to the election procedures of Article V hereof. The Salary Redirection shall be equal to the annual dollar amount of Premium for coverage under the Employer-Sponsored Plans in which the Participant is enrolled during the Plan Year and the amount elected by the Participant to purchase Benefits under the Plan for the Plan Year. The Plan Administrator may, in its discretion, fix a limit on the amount of Salary Redirection a Participant may elect for a Plan Year including for the purpose of complying with the Code and regulations there under.

4.2 **Pro Rata Deductions.** The elected amount shall be deducted from the Participant's Compensation on a pro rata basis during the Plan Year. If on any payday, a Participant's paycheck is insufficient to pay his or her pro rata elected amount, the Plan Administrator may require the Participant to pay the remaining pro rata amount with after-tax dollars.

ARTICLE V

PARTICIPATION, ELECTION AND CONTRIBUTIONS

5.1 **Annual Enrollment Election Period.** Prior to the start of each Plan Year (dates to be announced by the Plan Administrator each year); the Plan Administrator shall provide each Eligible Employee with the opportunity to become a Participant in the Plan for the upcoming Plan Year. An Eligible Employee may also decline to participate in the Pre-Tax Premium Account at this time.

5.2 **New Eligible Employees.** If an individual becomes an Eligible Employee after the Annual Enrollment Election Period has ended, such Eligible Employee may make an election/declination in the manner prescribed by the Plan Administrator to the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account within 31 days of his or her first day of eligibility.

5.3 **Participation and Elections.**

(a) **Pre-tax Premium Account** — An Eligible Employee's participation in the Pre-tax Premium Account is automatic provided such Eligible Employee has enrolled and is participating in any of the Employer-Sponsored Plans. If an Eligible Employee does not want to be a Participant in this account, such Eligible Employee must notify the Plan Administrator in writing, stating that he or she does not want to participate in the Pre-tax Premium Account. The Eligible Employee may do so either at the time he or she enrolls in the Employer-Sponsored Plans or during the Annual Enrollment Election Period prior to the beginning of each Plan Year.

(b) **Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account** — Each Eligible Employee must decide before the start of each Plan Year, the amount of such Eligible Employee's Compensation that he or she wants to redirect and receive as Benefits. Separate elections must be made for the Health Care Expense Reimbursement Account and the Dependent Care Expense Reimbursement Account. An Eligible Employee can elect Salary Redirection just to the Health Care Expense Reimbursement Account or just to the Dependent Care Expense Reimbursement Account, or the Eligible Employee can elect to contribute to both accounts or to neither account.

5.4 **Salary Redirection Agreement.** Each Eligible Employee must execute, in the manner as prescribed by the Plan Administrator, a Salary Redirection Agreement indicating how much he or she wishes to contribute to the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account and authorizing salary reduction. Such agreement must be made by the last day of each Annual Enrollment Election Period in order that an Eligible Employee may be a Participant in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account for the upcoming Plan Year. A new Eligible Employee must enroll within 31 days from his or her first day of eligibility.

5.5 **Acceptance of Elections.** A Salary Redirection Agreement executed by a Participant is subject to acceptance, modification or rejection by the Plan Administrator. The Plan Administrator may modify or reject a Participant's election in order to satisfy legal or Code requirements, or for other good cause. Rejection of an election for a Plan Year shall cause the Eligible Employee not to be a Participant in the Plan for that Plan Year, unless prior to the beginning of the Plan Year, the Plan Administrator, in its discretion, permits the Participant to file a new election.

5.6 **Payroll Deductions.** Payroll deductions for Participants who enroll in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account during the Annual Enrollment Election Period will begin on the Participant's first payday coinciding with or next following the first day of the Plan Year. Payroll deductions for Participants who become eligible after the Annual Enrollment Election Period who enroll in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account will begin as soon as administratively possible after the date of enrollment. Pre-tax payroll deductions for the Employer-Sponsored Plans will begin as soon as administratively possible after the Eligible Employee has met the eligibility requirements and enrolls in the Employer-Sponsored Plans, unless the Eligible Employee has previously declined participation in the Pre-Tax Premium Account.

5.7 **Failure to Complete the Salary Redirection Agreement.** Subject to Section 5.9, if an Eligible Employee does not execute a Salary Redirection Agreement for the Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account during the Annual Enrollment Election Period (or, if a new Eligible Employee, within 31 days of his or her first day of eligibility), the Eligible Employee's election for the Plan Year shall be deemed to be zero and no amounts will be deducted from the Eligible Employee's pay during the Plan Year to fund these accounts.

5.8 **Minimum and Maximum Salary Redirections.** A Participant's annual election to the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account can be in any whole dollar amount; however, a Participant must elect a minimum annual contribution of \$100. The maximum amount that a Participant may elect to each reimbursement account is as follows:

(a) **Health Care Expense Reimbursement Account** — A Participant's maximum annual contribution to the Health Care Expense Reimbursement Account is \$12,000. Effective January 1, 2013 the maximum annual contribution will be \$2,500 as mandated by the Affordable Care Act. The maximum annual contribution in subsequent years will be the inflation-adjusted limit published by the Department of the Treasury and/or the Internal Revenue Service.

(b) **Dependent Care Expense Reimbursement Account** — A Participant's maximum annual contribution is the smallest of (i) \$5,000, or (ii) if the Participant is married and files a separate federal income tax return, \$2,500, or (iii) if the Participant is married, the lesser of the Participant's or the spouse's earned income as defined in Section 32(c)(2) of the Code. A Participant's spouse who is a Full-Time Student or is not physically or mentally able to care for himself or herself shall be deemed to have earned income of \$250 for each month such spouse had such disability or Full-Time Student status (\$500 per month if the Participant has one or more qualifying Dependents other than his or her spouse).

5.9 **Change in Status.** Once a Participant has made or is deemed to have made his or her election for the Plan Year, that election will stay in effect for the entire Plan Year. A Participant can only change his or her election if he or she has a Change in Status, but only if election changes are necessary or appropriate as a result of the event giving rise to the Change in Status. The change to a Participant's annual election must be consistent with his or her event. The Participant may not, however, reduce his or her annual election to an amount less than the dollar amount of any reimbursable expenses submitted and to be submitted for the portion of the Plan Year ending prior to the date of such Participant's change of election or year-to-date contributions. A Participant must make a new election within 30 days of such Participant's Change in Status for it to be effective for the remainder of the Plan Year. Notwithstanding the foregoing, if the Participant, the Participant's spouse or the Participant's Dependent becomes eligible for continuation coverage as provided in Article IX ("Continuation Coverage") under an Employer-Sponsored Plan, the Participant may increase his or her election to pay for such coverage, provided that

this rule does not apply to a Participant's spouse who becomes eligible for Continuation Coverage as a result of divorce.

5.10 **Nondiscriminatory Benefits.** The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or Benefits, and to comply in this respect with the requirements of the Code and the regulations issued there under. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such Participants and/or reduce such Plan contributions and/or Benefits under the Plan in a uniform and non-discretionary manner, as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate. However, in no event shall such actions by the Plan Administrator result in a refund of elective contributions not used during a Plan Year or Grace Period in which contributions would have otherwise been forfeited.

ARTICLE VI

BENEFITS

6.1 **Benefits Options.** The Plan provides that a Participant may set aside a portion of his or her Compensation to pay his or her share of the Premiums under the Employer-Sponsored Plans, and also to make contributions to the Health Care Expense Reimbursement Account and to the Dependent Care Expense Reimbursement Account maintained under the Dependent Care Expense Reimbursement Plan.

6.2 **Pre-tax Premium Account.** The Pre-Tax Premium Account provides payment of a Participant's portion of the Premium cost of the Employer-Sponsored Plans.

6.3 **Health Care Expense Reimbursement Account.** The amount a Participant has elected on his or her Salary Redirection Agreement to be applied to his or her Health Care Expense Reimbursement Account will be used to reimburse such Participant for eligible medical expenses, subject to the following:

(a) **Eligible Medical Expenses.** Eligible medical expenses are expenses incurred for "medical care," as defined in Code Section 213(d)(1) and regulations thereunder, determined as follows:

(i) Eligible medical expenses shall include medicines and drugs purchased by the Participant or his spouse or Dependents without a physician's prescription. However, amounts paid for dietary supplements that are merely beneficial to the general health of the Participant or the Participant's spouse or Dependents, are not eligible medical expenses. Effective January 1, 2011, Eligible Medical Expenses shall no longer include medicines and drugs purchased by the Participant or his spouse or Dependent without a physician's prescription (except for insulin).

(ii) Eligible medical expenses shall not include an expense incurred for a Participant's premium payments for other health plan coverage, including premiums paid for health coverage under a plan maintained by an employer of the Participant's spouse or Dependent.

(b) **Limitations of Eligible Medical Expenses.** Limitations on eligible medical expenses include:

(i) Such expenses must be incurred by the Participant or the spouse or Dependents of the Participant;

(ii) The expenses are not covered, paid or reimbursed from any other source;

(iii) The expenses must be incurred during the Plan Year or Grace Period for which a Participant's election is made (expenses are treated as having been incurred on the date the services are provided);

- (iv) The expenses must be incurred while the Participant is participating in the Health Care Expense Reimbursement Account;
- (v) A Participant may not deduct such expenses on his or her income tax return; and
- (vi) The expenses may not exceed the amount that the Participant has elected to have credited to his Health Care Expense Reimbursement Account for the Plan Year (or the maximum reimbursement amount as provided in Section 5.8(a), if lesser) less previous reimbursements made from such account during the Plan Year and Grace Period.

6.4 **Dependent Care Expense Reimbursement Account.** The amount a Participant elects to be applied to such Participant's Dependent Care Expense Reimbursement Account will be used to reimburse such Participant for eligible dependent care expenses, subject to the following:

(a) **Eligible Dependent Care Expenses.** Eligible dependent care expenses are those expenses that would be considered "employment-related expenses" under Section 21(b)(2) of the Code (relating to expenses for household services and for the care of a qualifying dependent which are necessary for gainful employment) if paid for by a Participant.

(b) **Limitations on Eligible Dependent Care Expenses.** Limitations on eligible dependent care expenses include:

- (i) Expenses must be incurred for household services or for the care of one or more members of a Participant's home who are any of the following: (A) a Dependent who is under the age of 13, or (B) a Dependent or spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year.;
- (ii) They must be expenses which are not paid or reimbursed through another benefit plan or from any other source;
- (iii) Expenses must be incurred during the Plan Year and Grace Period for which a Participant's election is made (expenses are treated as incurred on the date the services are provided);
- (iv) Expenses must be incurred while the Participant is participating in the Dependent Care Expense Reimbursement Plan;
- (v) The total amount of reimbursements made in a year, under this and any other dependent care plan, cannot exceed a Participant's earned income (or if a Participant is married, the lesser of such Participant's earned income, or his or her spouse's earned income, determined as provided in Section 5.8(b)), during that taxable year;
- (vi) The expenses are necessary to enable a Participant and his or her spouse (if married) to be gainfully employed;
- (vii) A Participant's spouse must be gainfully employed, be a Full-Time Student or be physically or mentally incapable to care for himself or herself;
- (viii) If services were provided outside the Participant's home, such services must be incurred for the care of a qualifying Dependent under the age of 13, or for any other Qualifying Dependent who regularly spends at least (8) hours a day in the Participant's household;
- (ix) Services rendered in a Dependent Care Center as defined in Section 21(b)(2)(D) of the Code must satisfy the requirements of Section 21(b) of the Code and the regulations issued thereunder;

(x) The person providing the service to a Participant's Qualifying Dependent cannot be (A) an individual with respect to whom a deduction is allowable under Section 152 of the Code to such Participant or his or her spouse; (B) such Participant's spouse; or (C) a child of such Participant who is under 19 years of age at the end of the Plan Year in which the service is provided;

(xi) A Participant will not take a tax credit on his or her income tax return for the expenses which are reimbursed under the Dependent Care Expense Reimbursement Plan; and

(xii) In the event that the amount in the Dependent Care Expense Reimbursement Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months (within the same Plan Year), to be paid out as the account balance becomes adequate. In no event will the amount of eligible dependent care expenses reimbursement exceed the amount credited to the Dependent Care Expense Reimbursement Account for any Plan Year.

6.5 **Cash Benefit.** To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as Salary Redirection, such amount not elected shall be paid to the Participant in the form of normal Compensation payments.

6.6 **Limitation of Benefits.** In no event shall the total Premiums or Benefits paid with respect to the Benefits selected by a Participant for any Plan Year exceed the amount by which such Participant elected or is deemed to have elected to reduce his or her cash Compensation in his or her Salary Redirection Agreement.

Each of the various Qualified Benefits, which are or may be offered by the Employer under the Plan, may have limitations, in addition to any limitations provided herein, and the separate limitations with respect to any particular Qualified Benefits shall govern where applicable.

6.7 **Statement of Benefits.** The Plan Administrator may periodically furnish each Participant with a statement showing the amounts paid by the Employer in providing health care and/or dependent care reimbursement and the respective reimbursement account balance(s).

6.8 **Nature of Accounts.** No money shall actually be allocated to any account. Any such account shall be of a memorandum nature, maintained by the Plan Administrator (or designee) for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to any account.

6.9 **Forfeitures.** Subject to Section 7.5 hereof, any amount credited to a Participant's Health Care Expense Reimbursement Account or Dependent Care Expense Reimbursement Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement on or before the last day of the third month following the end of the Plan Year and Grace Period for which the election to contribute such amount was effective. Amounts so forfeited shall be used to offset administrative expenses or any use that is permitted within the applicable Department of Labor or Internal Revenue Service regulations.

6.10 **Benefits Under Employer-Sponsored Plans.** The Benefits provided in the Employer-Sponsored Plans and are not governed or provided under this Plan.

ARTICLE VII

REIMBURSEMENT PROCEDURES

7.1 **Request for Reimbursement.** When a Participant has incurred expenses eligible for reimbursement from the Health Care or Dependent Care Expense Reimbursement Account, such Participant must complete an expense reimbursement request form and forward it as specified in the Summary Plan Description and procedure required by the Plan Administrator. Distributions from a Participant's accounts to pay for an eligible

health or dependent care expense will only be made for services that have already been performed, even though such Participant may have previously paid the provider for such services.

7.2 **Documentation.**

(a) If a Participant has an **eligible medical expense**, such Participant must submit a statement from the service provider showing the name and address of the service provider, the date services were performed, type of service(s), and amount(s) charged.

If the eligible medical expense is covered by the Employer-Sponsored Plan or by any other medical or dental plan, a Participant should file a claim first with that plan. The amount not paid by that plan is the amount such Participant can claim for reimbursement. The explanation of benefits form a Participant receives detailing what was covered under your plans, or any other documentation deemed suitable by the Claims Administrator, should be submitted as part of a Participant's medical expense reimbursement claim.

(b) If a Participant has an **eligible dependent care expense**, such Participant must submit either a statement from the service provider or from himself or herself which shows the name and address of the service provider, the dates on which services were provided, the taxpayer identification number of the service provider (or, if an individual, the individual's social security number) and the amount charged.

If a Participant does not file the appropriate form for reimbursement, or fails to provide the information required to verify that the expense is eligible for reimbursement, payments to such Participant could be delayed or denied.

7.3 **Processing Frequency.** Reimbursement requests are processed semi-monthly or at such other frequency as determined from time to time by the Plan Administrator. For the Health Care Expense Reimbursement Account, reimbursement requests will be paid up to the amount of a Participant's Plan Year election. For the Dependent Care Expense Reimbursement Account, if the balance in a Participant's account is enough to reimburse the entire expense, such Participant will receive a check for the full amount. If the dependent care expenses are for more than a Participant's balance, the remaining amount of such Participant's reimbursement request will be carried over to the next period within the same Plan Year and will be paid once new contributions are made to such Participant's account. In no event will expenses incurred be carried over to any subsequent Plan Year.

7.4 **No Guarantee of Non-Tax.** Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts reimbursed to or for a Participant will be excludable from such Participant's gross income and properly reported on applicable tax returns.

7.5 **Request for Reimbursement Submission's Period.** Any eligible expenses, which a Participant incurs during the Plan Year or Grace Period, can be submitted for reimbursement at any time during that Plan Year or Grace Period and up to the last day of the third month following the end of the Plan year.

ARTICLE VIII

TERMINATION OF PARTICIPATION; LEAVES OF ABSENCE

8.1 **Contributions Cease.** Except as provided in Article IX, a Participant's contributions to the Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account, as well as the pre-tax payment of the Employer-Sponsored Plans Premiums will cease on the earlier of the last day of the payroll period in which a Participant receives compensation, or the last day of the payroll period in which a Participant ceases to be an Eligible Employee due to:

- (a) Participant's termination of employment (voluntary or involuntary), retirement or death;
- (b) Participant's absence from work for any reason if Participant's pay stops (except as provided in Section 3.4); or

- (c) Participant's reduction in hours worked below the minimum required to participate.

Contributions will also stop at the end of each Plan Year.

8.2 **Participation and Benefits Cease.**

- (a) **Pre-Tax Premium Account** — A Participant's participation ends when his or her contributions cease as provided in Section 8.1 or when a Premium payment for the applicable Employer-Sponsored Plan(s) has been missed for any reason.
- (b) **Health Care Expense Reimbursement Account** — A Participant's participation in the Health Care Expense Reimbursement Account ends on the date the Participant ceases to be an Eligible Employee as provided in Section 8.1.

Unless Continuation Coverage is elected (see Article IX), reimbursement payments to such Participant shall not be made with respect to any health care expense incurred after the date the Participant ceased to be an Eligible Employee. Claims for reimbursement of eligible expenses incurred prior to the date the Participant ceased to be an Eligible Employee can be submitted up to the last day of the third month following the end of the Plan Year. Any unreimbursed contributions will not be returned to the Participant.

- (c) **Dependent Care Expense Reimbursement Account** — A Participant's participation in the Dependent Care Expense Reimbursement Account ends on the date the Participant ceases to be an Eligible Employee as provided in Section 8.1.

Reimbursement payments to such Participant shall not be made with respect to any eligible dependent care expense incurred after the date the Participant ceased to be an Eligible Employee. Claims for reimbursement of eligible expenses incurred prior to the date the Participant ceased to be an Eligible Employee can be submitted up to the last day of the third month following the end of the Plan Year. Any unreimbursed contributions will not be returned to the Participant.

8.3 **Group Health Plan Continuation Coverage.** Each benefit plan made available under Article VI hereof which is considered to be a "group health plan" under Section 4980B(g)(2) of the Code, because employees and their families are provided with health care benefits within the meaning of Section 5000(b)(1) of the Code, shall contain the necessary provisions required by Section 4980B of the Code and §601 of ERISA, to assure that such benefits may be continued on or after the occurrence of the qualifying events defined in Section 4980B(f)(3) of the Code. (See Article IX. "Continuation Coverage," hereof for this Plan's provisions.)

8.4 **Leaves of Absence.** The Plan shall be administered in accordance with the Family and Medical Leave Act of 1993 ("FMLA") as well as the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), to the extent each may be applicable to the Plan. The Plan Administrator shall maintain procedures, as the same may be amended from time to time, and is incorporated herein by reference and made a part hereof.

8.5 **Qualified Medical Child Support Order ("QMCSO").** The components of this Plan that are group health plans extend benefits to a Participant's noncustodial child, as required by any QMCSO, as defined in ERISA Section 609(a). The Plan Administrator shall maintain procedures, as the same may be amended from time to time, and are incorporated herein by reference and made a part hereof.

8.6 **Newborns' and Mothers' Health Protection Act of 1996.** Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn

earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ARTICLE IX

CONTINUATION COVERAGE

9.1 **Availability of Continued Health Care Expense Reimbursement Account Benefits.** The Health Care Expense Reimbursement Account Benefits will be available to all persons for whom such Benefits would otherwise terminate due to a Qualifying Event described in Sections 9.3 hereof, and who qualify under the terms of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”) and subsequent related regulations and amendments, subject to limitation described in Section 9.6. Anyone eligible to elect to Continue Coverage under this Article IX shall be referred to herein as a "Qualified Beneficiary." Such term shall also include a child who is born to or placed for adoption with an Eligible Employee during the period of Continuation Coverage.

9.2 **Purchase of Health Benefits at 102% of Cost.** A Qualified Beneficiary whose Health Care Expense Reimbursement Account Benefits have been terminated for any Qualifying Event enumerated in Section 9.3 hereof has the right to continue in the Health Care Expense Reimbursement Account for all health care benefits which under the Health Care Expense Reimbursement Account the Qualified Beneficiary was entitled to receive on the day immediately preceding the date of the Qualifying Event, in accordance with Section 9.6. One Hundred Two Percent (102%) of the full cost of providing such coverage shall be charged to any person continuing in the Health Care Expense Reimbursement Account.

9.3 **Qualifying Events Triggering Continuation Coverage.** “Continuation Coverage” means the Participant’s right, or the Participant’s spouse’s or Participant’s dependent’s right to continue to be covered under the Health Care Expense Reimbursement Account if participation by the Participant (including the Participant’s spouse and dependents) otherwise would end due to the occurrence of a “Qualifying Event.” A “Qualifying Event” is:

- (a) the termination of employment by a Participant who is an Eligible Employee for any reason except gross misconduct;
- (b) the loss of eligibility of a previously Eligible Employee to participate in the Health Care Expense Reimbursement Account due to reduced work hours;
- (c) death of a Participant who is an Eligible Employee;
- (d) divorce or legal separation of a Participant from the Participant’s spouse;
- (e) a covered Dependent child's loss of eligibility to participate in the Health Care Expense Reimbursement Account due to age or a change in student status; or
- (f) the Participant becomes entitled to Medicare.

9.4 **Other Qualifying Event Rules.** In the case of any loss of coverage due to the commencement of a bankruptcy proceeding with respect to the Employer, the rules governing the maximum period of continuation coverage under the Code are described in Section 9.6 below.

A Participant who is absent from work for more than thirty-one (31) days to fulfill a period of duty in the "Uniformed Services", as such term is defined hereinafter, shall experience a Qualifying Event as of the first day of the Participant's absence for such duty. In that event, the Participant and any of the Participant's covered dependents shall be treated as Qualified Beneficiaries for purposes of COBRA. As used herein, the term "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, full-time National Guard duty, the commissioned corps of

the Public Health Service, or any other category of persons designated from time to time by the President of the United States in time of war or emergency.

9.5 **Notification Rules.** For a Qualifying Event other than a change in the employment status of the Eligible Employee, the Eligible Employee or Qualified Beneficiary is required to notify the Plan Administrator within sixty (60) days of a Qualifying Event described in Section 9.3 (c), (d), (e) or (f) hereof. If an Eligible Employee or Qualified Beneficiary fails to provide such notice, the Qualified Beneficiary shall lose his or her right to elect continuation of coverage under this Article IX. The Employer is required to notify the Plan Administrator within thirty (30) days of a Qualifying Event described in Section 9.3 (a) or (b). The Plan Administrator shall notify each Qualified Beneficiary of his or her right to continuation of coverage within fourteen (14) days of the notice made to the Plan Administrator of the Qualifying Event. The Eligible Employee or covered Dependent is also required to provide the Plan Administrator with all information needed to meet its obligation of providing notice and Continuation Coverage.

9.6 **Limitation on Continuation Coverage.** Certain Eligible Employees and/or Qualified Beneficiaries will be eligible for COBRA Continuation Coverage if the Participant has a **positive** Health Care Expense Reimbursement Account balance at the time of the Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). Eligible Employees and/or Qualified Beneficiaries will be provided information as to the possibility of COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA Continuation Coverage for the Health Care Expense Reimbursement Account will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Eligible Employees and/or Qualified Beneficiaries will not be eligible for COBRA Continuation Coverage if the Participant has a **negative** Health Care Expense Reimbursement Account balance at the time of the Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event.)

9.7 **Termination of Continuation Coverage.** Continuation of the Health Care Expense Reimbursement Account Benefits shall not be provided beyond whichever of the following dates is first to occur:

- (a) the last day of the Plan Year in which the Qualifying Event occurs;
- (b) the date of termination of the health Benefit elected under the Health Care Expense Reimbursement Account, together with all other health benefits provided by the Employer that have been continued under continuation of health benefit rules;
- (c) the date the Eligible Employee or Qualified Beneficiary fails to pay the applicable Health Care Expense Reimbursement Account Contribution on time;
- (d) the date the Eligible Employee or Qualified Beneficiary becomes covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Beneficiary; or
- (e) the date the Eligible Employee or Qualified Beneficiary becomes entitled to Medicare.

ARTICLE X

PLAN ADMINISTRATION

10.1 **Administrative Responsibility.** The Plan will be administered by the Plan Administrator. It shall be the principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms for the exclusive benefit of the Participants of the Plan. In addition to the provisions set forth herein, the administration of the Plan shall be subject to the terms of any written agreement executed between the Employer and the Plan Administrator in connection with the implementation of the Plan, as such written agreement may be amended from time to time. The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

- (a) To construe and interpret the Plan, decide all questions of eligibility, and to determine the amount, manner, and term of payment of any Benefits hereunder;
- (b) To prescribe procedures to be followed by the Participants filing applications for Benefits, including modification of any procedures set forth in this Plan;
- (c) To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;
- (d) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;
- (e) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
- (f) To receive, review and retain reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Plan Administrator;
- (g) To appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuary counsel, claims administration and;
- (h) To modify any provision of the Plan if such modification is necessary for the Plan to comply with the Code and the regulations issued thereunder.

The Plan Administrator may rely upon any direction, information, or action of any employee of the Employer as being proper under the Plan and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that the Plan Administrator shall not be responsible for any act or failure to act of any other employee of the Employer.

10.2 **Appointment of Plan Administrator.** The Employer may designate any person, firm or entity to serve as Plan Administrator. If no such person, firm or entity is named; the Plan Administrator is the Employer. All usual and reasonable expenses of the Plan Administrator shall be paid in whole by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Plan Administrator personally.

10.3 **Bonding.** Unless otherwise determined by the Employer, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of the Plan.

10.4 **Records and Reports.** The Plan Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances which are payable under the Plan.

10.5 **Rules and Decision.** The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate to administer the Plan, and all rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer or any other agent rendering services to the Plan or the Plan Administrator.

10.6 **Authorization of Benefit Payments.** The Plan Administrator may issue directions to the Employer concerning all Benefits, which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

10.7 **Application and Forms for Benefit.** The Plan Administrator may require a Participant to complete and file with the Claims Administrator an application for a Benefit and all other forms approved by the

Plan Administrator and to furnish all pertinent information requested by the Claims Administrator. The Claims Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.

10.8 **Facility of Payment.** Whenever the Plan Administrator's opinion on a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage his or her financial affairs, the Plan Administrator may make payments to such person or to such person's conservator, attorney-in-fact, or other legal representative of such person, or apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the provisions hereof shall be a complete discharge of any liability of the Plan Administrator.

ARTICLE XI

ERISA PROVISIONS

11.1 **Claim For Benefits.** Any claim for benefits underwritten by an insurance contract shall be made to the insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the insurer's claims review procedure. Any other claim for Benefits shall be made to the Plan Administrator. If the Plan Administrator denies a claim, the Plan Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Plan Administrator does not notify the Participant of the denial of the claim within the 90-day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (a) specific references to the pertinent Plan provisions on which the denial is based;
- (b) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
- (c) an explanation of the Plan's claim procedure.

Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Plan Administrator for a full and fair review. The claimant or his duly authorized representative may:

- (a) request a review upon written notice to the Plan Administrator;
- (b) review pertinent documents; and
- (c) submit issues and comments in writing.

A decision on the review by the Plan Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

Any balance remaining in the Participants' Health Care Expense Reimbursement Account or Dependent Care Expense Reimbursement Account as of the end of each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.9, unless the Participant had made a timely claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

Notwithstanding the foregoing, in the case of a claim for medical expenses under the Health Care Expense Reimbursement Account, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial.
- (b) Reference to the specific Plan provisions on which the denial was based.
- (c) 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.
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

11.2 **Non-ERISA Claims under Cafeteria Plan Feature and Dependent Care Plan.** Except where a claim specifically relates to an Employer-sponsored Plan subject to ERISA, claims relating to the administration of Code Section 125 pre-tax elections, any decision regarding the qualifying event for election change under Section 5.9, or the Dependent Care Plan shall be reviewed by the Plan Administrator and decided in a uniform and non-discriminatory manner pursuant to applicable regulations under Code Sections 125 and 129.

11.3 **Preservation of Remedies.** After exhaustion of the claims procedure as provided under the Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

ARTICLE XII

MISCELLANEOUS

12.1 **Non-Alienation of Benefits.** Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Eligible Employee, prior to actually being received by the person entitled to the Benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge encumbrance, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contract, liabilities, engagements, or torts of any person entitled to Benefits hereunder.

12.2 **No Guarantee of Employment.** Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any employee or as a right of any employee to be continued in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

12.3 **Amendment or Termination of the Plan.** The Employer has established the Plan with the intent that it will be maintained for an indefinite period of time. The Employer intends that the terms of the Plan, and each Eligible Employee's rights thereunder, including those related to coverage and Benefits, shall be legally enforceable and that the Plan shall be maintained for the exclusive benefit of the Eligible Employees. Except as provided in Section 10.1 hereof, the right to alter, amend, suspend, or terminate the Plan is reserved to the Employer. If the Plan is terminated, all enrollment elections with respect to the Plan shall terminate.

12.4 **Insurer Not a Party.** No insurer shall be considered a party to the Plan. The rights and obligations of any insurer are those specified in the insurance policy and no provision of the Plan shall be deemed to alter or change the terms of such contract.

12.5 **Notice of Address.** Each person entitled to Benefits under the Plan must file with the Plan Administrator (or designee), in writing, his mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the Plan, and there shall be no obligation on the part of the Employer, the Plan Administrator or any trustee or insurer to search for or to ascertain the location of such person.

12.6 **Source of Payments.** To the extent a Participant's salary or wages are reduced to provide non-cash Benefits through the Plan, these reduced amounts become Employer contributions to the Plan. The Employer pays any Benefits to which a Participant is entitled under the Plan from its general assets.

12.7 **No Obligation to Insure or Fund Benefits.** The Employer shall have no obligation, but shall have the right, to insure any Benefits under the Plan or to establish any fund or trust for the payment of Benefits under the Plan except as mandated by law.

12.8 **Indemnification by Employer.** To the extent allowed by law, the Employer does hereby indemnify and hold harmless any person, corporation, professional association or partnership that is deemed to be a fiduciary of the Plan under the terms and provisions of ERISA, the regulations promulgated thereunder and case law which develops, against any and all losses, claims, damages, expense (including court costs and attorney's fees) and liability arising from their duties and responsibilities in connection with the Plan unless the same is due to willful or wanton misconduct.

12.9 **Indemnification of Employer by Participants.** If a Participant receives one or more payments or reimbursements under the Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that a Participant would have owed if the payments or reimbursements had been made to such Participant as regular cash compensation, plus such Participant's share of any social security tax that would have been paid on such compensation, less any such additional income and social security tax actually paid by the Participant.

12.10 **Applicable Law.** The Plan shall be construed and interpreted in accordance with the laws of the State of New York to the extent the terms thereof are not preempted by the Federal law.

12.11 **Captions.** The captions or headings in the Plan are made for convenience and shall not be construed to describe, define, or limit the scope or intent of the Plan.

12.12 **Severability.** Should any part of the Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

ARTICLE XIII

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT

13.1 **Permissible Uses and Disclosures.** The Plan and the Sponsor shall only use or disclose Protected Health Information (“PHI”) to the extent it is permitted under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). As permitted under HIPAA, the Plan and the Sponsor shall only use or disclose PHI for the following purposes:

- for Payment of benefits or Health Care Operations;
- disclosure to a Participant who requests his or her own information;
- disclosures pursuant to a valid authorization by the Participant or a representative of the Participant;
- disclosures to the Department of Health and Human Services (“HHS”); and
- disclosures that are required by law.

The Plan is permitted to disclose PHI to the Sponsor because the Sponsor has agreed to the limitations on the uses and disclosures of PHI discussed in this Article XIII.

13.2 **Adequate Separation Between Plan and the Sponsor.** Only employees of the Sponsor who perform plan administrative functions for the Plan shall have access to or be able to use PHI. Only the following classes of employees may be given or afforded such access or use:

- employee benefits department employees: benefits manager, benefits specialists, analysts and their staff;
- financial services department employees who reimburse employees based upon the employee benefits department’s request; and
- legal counsel responsible for Plan-related issues.

The access or use of PHI by these employees is restricted to Plan functions that these employees perform for the Plan.

13.3 **Certification by the Plan.** The Plan will disclose PHI to the Sponsor only upon receipt of a certification by the Sponsor that the Plan documents have been amended to provide, and the Sponsor agrees to abide by, the following provisions:

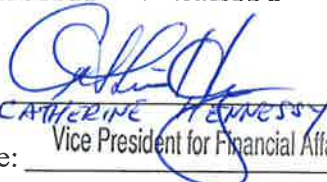
- Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Sponsor with respect to such information;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not to use or disclose PHI in connection with any other benefit or employee benefit plan of the Sponsor unless authorized by an individual;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA’s access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosures of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan’s compliance with HIPAA; and
- Return or destroy, if feasible, all PHI received from the Plan that the Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which 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).

13.4 **Noncompliance Issues.** If the persons described in Section 13.2, above, do not comply with these provisions, the Sponsor will take measures to ensure future compliance, including disciplinary sanctions such as suspension, reassignment, or discharge.

13.5 **Definitions.** Capitalized terms used in this Article XIII, to the extent not defined elsewhere in the Plan, shall have the meaning, if any, provided by 45 CFR 164.501. Protected Health Information shall include information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future reimbursement of medical or dental expenses to an individual, and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes information of persons living or dead.

IN WITNESS WHEREOF, the Sponsor has executed this Plan as of the date set forth below.

HOFSTRA UNIVERSITY

By: 
CATHERINE HENNESSY
Vice President for Financial Affairs and Treasurer
Date: 7-11-12

Qualifying Events Matrix

All changes must be consistent with the respective qualifying event

Event	Pre-Tax Premium Account	Health Care Expense Reimbursement Account	Dependent Care Expense Reimbursement Account
1. Gain/Lose a dependent(s) (birth, adoption, placement for adoption, death of dependent)	Pre-Tax medical/dental premium will automatically change if coverage changes.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
2. Change in legal marital status (including marriage, divorce, death of spouse, legal separation or annulment)	Pre-Tax medical/dental premium will automatically change if coverage changes.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
3. Change in employment status of employee spouse or dependent (termination or commencement of employment, change in worksite, or a spouse's or dependent's commencement or return from unpaid leave of absence) if eligibility is impacted under employee's spouse	Pre-Tax medical/dental premium will automatically change if coverage changes.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
4. Change in work Status affecting eligibility of employee, spouse or dependent - including a switch between part-time (below 20 hours per week for employees) and full-time or salary to hourly triggering eligibility	Pre-tax medical/dental premium will automatically change if coverage changes. (Employee switch between part-time/full-time will either terminate account [stop pre-tax contributions] or start automatic participation [same as 7, below] as is consistent with	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
5. Change in residence of employee, spouse or dependent	Pre-tax medical/dental premium will automatically change if underlying health plan coverage.	No change permitted.	No change permitted.
6. Employee's dependent satisfies (or ceases to satisfy) dependent eligibility requirements (attained age, gain or loss of student status, marriage or similar circumstance)	Pre-Tax medical/dental premium will automatically change if coverage changes.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
7. New employee is hired	Participation is automatic, first day of the month following, unless elect out	Eligible to participate first day of the month following. Must elect within sixty (60) days of hire.	Eligible to participate first day of the month following. Must elect within sixty (60) days of hire.
8. Paid Leave of Absence (12 months or less)	No change permitted.	No change permitted.	No change permitted if you still incur eligible expenses.
9. Judgment, decree or order (requires coverage under employee's plan or coverage under spouse's or former spouse's employer's plan)	Pre-Tax medical/dental premium will automatically change if coverage changes.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	No change permitted.
10. Employee voluntary or involuntary termination	Automatic termination. Stop pre-tax contributions.	Benefits cease as of the date of termination unless contributions for balance of Plan year are pre-paid within thirty (30) days or COBRA continuation is elected. May submit claims for expenses incurred to date of change up to two months after end of Plan	Benefits cease as of the date of termination unless contributions for balance of Plan Year are pre-paid within thirty (30) days. May submit claims for expenses incurred to date of change up to two months after end of Plan Year.
11. Family Medical Leave Act (FMLA)	Contact HR Department	Contact HR Department	Contact HR Department
12. Rehire	Same as new employee. However, if rehired within 30 days, steps back into prior election. If rehired after 30 days of termination and within the same Plan Year cannot re-elect until the next Plan Year.	Same as new employee. However, if rehired within 30 days, cannot re-elect but must return to election prior to termination. If rehired after 30 days of termination and within the same Plan year cannot re-elect until next Plan Year.	Same as new employee. However, if rehired within 30 days, cannot re-elect but must return to election prior to termination. If rehired after 30 days of termination and within the same Plan year cannot re-elect until next Plan Year.
13. Employee, spouse or dependent become entitled to or loses eligibility for Medicare or Medicaid	Pre-tax medical/dental premium will automatically change if coverage changes (dental is not permitted).	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.	No change permitted.
14. HIPAA special enrollment rights	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	No change permitted.
15. Costs changes with automatic increase/decrease in premium contributions (including employer motivated changes and changes in employee contribution rates)	Pre-tax medical/dental premium will automatically change	No change permitted.	No change permitted.
16. Significant cost increase	Pre-tax medical/dental premium will automatically change	No change permitted.	May increase election or revoke election if there is not similar alternative care. (No change permitted if dependent care provider is a relative.)
17. Significant cost decrease	Pre-tax medical/dental premium will automatically change	No change permitted.	May elect dependent care coverage or decrease election, but not below year-to-date contributions or claims reimbursed (No change permitted if dependent care provider is a relative.)

18. Significant coverage curtailment with loss of coverage	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
19. Significant coverage curtailment without loss of coverage	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	May change contributions consistent with event, but not below year-to-date contributions or claims reimbursed.
20. Addition or significant improvement of benefit option package	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	Employee (whether participating or not) may revoke election or make new election.
21. Change in coverage under other employer's cafeteria plan or qualified benefit plan (i.e. other employer's plan increases, decreases or ceases coverage or other employer's open enrollment). This exception allows election changes (1) when the other employe	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	May change contributions consistent with the event, but not below year-to-date contributions or claims reimbursed.
22. Loss of coverage under group health plan of governmental or educational institution	Pre-Tax medical/dental premium will automatically change if coverage changes.	No change permitted.	No change permitted.
23. Going on unpaid Leave of Absence (LOA)	Automatic termination if LOA is greater than 30 days. Stop pre-tax contributions. Participation can be continued after-tax if health insurance continued while on leave.	Participation ends if LOA is greater than 30 days. May continue to participate if account is pre-paid.	Participation ends if LOA is greater than 30 days. May continue to participate if account is pre-paid.
24. Return from an unpaid Leave of Absence (LOA) greater than 30 days	Participation resumes if health insurance continued while on leave.	Participation ended when LOA began if account was not pre-paid. No changes permitted for the current plan year.	Participation ended when LOA began if account was not pre-paid. No changes permitted for the current plan year.

*Other restrictions may apply and additional situations may be considered qualifying events under IRS rules. Check your Summary Plan Description.