Butler University
Flexible Spending Account Plan
Summary Plan Description

Issued November 2015
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WHAT IS THE PURPOSE OF THIS SUMMARY?

The purpose of this Summary is to help you understand the benefit features offered to you under the Butler University Flexible Spending Account Plan (the "Plan").

The Plan allows you to reduce your salary by a certain amount on a pre-tax basis, and use that amount to pay for your cost of coverage under certain welfare benefit plans, called Qualified Benefits, to provide coverage under a Health Care Reimbursement Account or a Dependent Care Reimbursement Account, and/or to contribute to a Health Savings Account ("HSA") on a pre-tax basis.

If you participate in the Plan, you will not pay federal, state, local, or Social Security taxes on these pre-tax contributions. However, they may reduce your future Social Security benefits.

CAUTION

This Summary describes the principal terms and conditions of the Plan as of January 1, 2015, for Employees of the University. The Plan is a benefit feature established under the Butler University Employee Benefit Plan ("Employee Benefit Plan").

The Employee Benefit Plan and Plan are the documents that legally govern the terms and operations of the Plan and create any rights for you or your beneficiary(ies). If there are any differences between this Summary and the Employee Benefit Plan document or Plan document, the Employee Benefit Plan document and Plan document will control.

Further details about the Plan are on file at Butler University ("University"), 4600 Sunset Avenue, Indianapolis, IN 46208. You are welcome to review this document by simply calling Human Resources Management and Development at (317) 940-9044.

DEFINED TERMS

A few defined words and phrases are used in this Summary. Please refer to the Key Definitions section when the first letter of a word or phrase is capitalized.
PARTICIPATION

A. When Participation Begins.

If you are an Eligible Employee, you will become a Participant under the Plan:

- with respect to paying your share of the premium for coverage under the Medical Plan, Dental Plan and/or Vision Plan (called "Qualified Benefits"), when you become a participant under the Qualified Benefit and elect coverage under the Plan,

- with respect to the General Purpose Health Care Account, the first payroll following the date of hire when you elect coverage under the Plan,

- with respect to the Limited Purpose Health Care Account, the first payroll following the date of hire when you elect coverage under the Plan if you are enrolled in a HDHP under the Medical Plan,

- with respect to the Dependent Care Account, the first payroll following the date of hire when you elect coverage under the Plan, and

- with respect to a Health Savings Account (HSA), the first payroll following the date you become an HSA Eligible Employee when you elect coverage under the Plan.

B. When Participation Ends.

You will no longer be a Participant under the Plan on the earlier of:

- the date the Plan or the Employee Benefit Plan terminates;

- the date you terminate employment with the University or retire;

- the date you revoke your election to participate when such a change is permitted under the Plan;

- with respect to pre-tax premium deductions for Qualified Benefits, the end of the month in which coverage under the underlying Qualified Benefit ends or COBRA coverage begins;

- with respect to your Accounts, as set forth in this Summary on pages 7 and 9; or

- the end of the month you stop making required contributions.

If you are no longer a Participant under the Plan, you may still be entitled to continue Qualified Benefits coverage as provided under the plans or policies which govern such Qualified Benefits.

C. Rehired Employees.

If you participate in the Plan, then terminate employment with the University, and then you return to employment with the University, the following rules apply:

- If you return to employment within 30 days and within the same Plan Year, you will be reinstated with the same election you had prior to termination.

- If you return to employment within 30 days and your absence spans two Plan Years, you must make a new election under the Plan for the remainder of the Plan Year.

- If you return to employment more than 30 days after you terminate employment, you must again meet the eligibility requirements listed above and make a new election under the Plan for the remainder of the Plan Year.
D. Unpaid Leaves of Absence that Qualify under the FMLA.

Stopping Your Contributions. If you take an unpaid FMLA leave of absence, you may stop your contributions and end coverage under the Plan for the duration of the FMLA leave. You may then again elect coverage for Qualified Benefits and coverage under the Health Care Reimbursement Account when you return from unpaid FMLA leave during the same Plan Year.

If you stop making contributions to the Health Care Reimbursement Account while on unpaid FMLA leave, you will not be entitled to reimbursement of Qualifying Health Care Expenses that are Incurred during such leave. If you return from FMLA leave during the same Plan Year, you will need to make a new election to reinstate coverage. You may:

- resume coverage at a reduced level and resume premium payments at the level in effect before the leave, in which case your coverage will be prorated for the period of the leave for which no premiums were paid, or

- resume coverage at the same level in effect before your FMLA leave and make-up any unpaid contributions.

Your coverage level will be reduced by any prior reimbursements made from your Health Care Reimbursement Account.

Continuing Your Contributions. If you decide to continue contributions and coverage while on an unpaid FMLA leave, payments may be made under the University's rules for payments made on an unpaid leave. In addition, when you return from an unpaid FMLA leave, you may make a new election for the remainder of the Plan Year if allowed under the section titled Changes in Elections During the Year.

E. Unpaid Leaves of Absence that Do Not Qualify under the FMLA.

If you take an unpaid leave of absence that does not qualify as an FMLA leave, you may remit payment on an after-tax basis to the Administrator or terminate coverage under the Plan. If coverage continues during the unpaid leave of absence, upon your return from leave, your elections will continue in effect for the remainder of the Plan Year. If you elected to terminate coverage during the unpaid leave of absence, you may not make a new election under the Plan for that Plan Year upon return from the leave, except as permitted under the section titled Changes in Elections During the Year.

AVAILABLE BENEFITS

Once you become eligible to participate in the Plan, you may elect to reduce your salary each pay period on a pre-tax basis, in an amount equal to your cost for Qualified Benefits. The cost may change each year. You will be informed of the amount of contributions for Qualified Benefits.

You may also reduce your salary, on a pre-tax basis, to participate in the Health Care Reimbursement Account and/or Dependent Care Reimbursement Account, or to make contributions to a HSA.

Your share of the benefit costs will be deducted from your pay in equal amounts for each pay period during the Plan Year. You will not be required to pay federal, state, or local income taxes or Social Security taxes on any pre-tax reduction amounts.
Example: Assume your annual salary is $25,000, you are married and claim two withholding allowances, and your spouse does not work. See what happens if you participate in the Plan compared to what happens if you don’t:

<table>
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<th>If You DON’T Participate</th>
<th>If You DO Participate</th>
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<tr>
<td>$25,000</td>
<td>$25,000</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td>-2,000</td>
<td>- N/A</td>
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<td>$20,063</td>
<td>$20,475</td>
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Savings $412  

In this example, you would be contributing the same $2,000, but by making your premium payments on a pre-tax basis, you increase your "spendable" pay by $412. Please note that this example shows only estimated state, federal and Social Security tax savings.

ELECTIONS UNDER THE PLAN

A. Enrollment Form.

You will receive enrollment materials describing the Plan. You must file a completed enrollment form with the Administrator during the applicable election period in order to participate in the Plan.

B. Election When You First Become Eligible.

To make an election for the Plan Year in which you first become an Eligible Employee, you must make an election and submit a completed enrollment form to the Administrator no later than 31 days after becoming an Eligible Employee. Your election will be effective on the first pay period following the filing of the election form with the Administrator.

If, in your initial year of eligibility, you do not return a completed enrollment form to the Administrator on or before the specified due date, you will be deemed to have elected:

- not to receive Qualified Benefits on a pre-tax basis,
- not to have your salary reduced to participate in the Accounts, and
- not to have your salary reduced to credit amounts under the HSA.

C. Annual Enrollments.

For each Plan Year after the Plan Year in which you first become an Eligible Employee, you may make an election to:

1. change your current coverage,
2. stop your coverage, or
3. begin coverage,

as applicable, by submitting a completed enrollment form to the Administrator on or before the last day of the open enrollment period prior to the next Plan Year (generally during the last quarter of a Plan Year unless the University provides otherwise). Your election will be effective on the first day of the next Plan Year.

If you do not return an enrollment form to the Administrator on or before the specified due date for the next Plan Year (regardless of any election in effect for the current Plan Year), you will be deemed to have elected:

- not to receive Qualified Benefits on a pre-tax basis,
- not to have your salary reduced to participate in the Accounts, and
- not to have your salary reduced to credit amounts under the HSA.
D. Health Savings Account Elections.

The enrollment rules are different for HSAs. If you are eligible to establish an HSA, you may elect to begin contributions to the HSA at any time. However, you must establish an HSA account before electing to make contributions to an HSA. You may establish an HSA account at any time following your enrollment in the HDHP under the Medical Plan.

E. Changes in Election During the Year.

An election may only be changed during the Plan Year if you have a change in status or other applicable event that affects your coverage. These changes are called "life events." To change or end an election due to a change in status or other applicable event, you must submit a completed enrollment form to the University within 31 days of the status change or event (60 days in the event of a special enrollment event regarding eligibility under Medicaid or a state children's health insurance Program ("CHIP"), see below). The election will be effective no later than the first of the month following the date of the change in status or applicable event (but may be earlier as required under HIPAA), provided a written form notifying the Claims Supervisor of the change is filed with the Claims Supervisor.

Changes in Status.

You may begin, change or cancel an election to participate in the Plan during the year if you have a change in status. Your election must be on account of the change in status, necessary or appropriate as a result of the status change, and consistent with the terms and conditions of the Qualified Benefits.

"Changes in status" include:

- a change in your legal marital status, including
  - death of a spouse,
  - divorce,
  - marriage,
- legal separation or annulment of your marriage;
- a change in the number of your dependents, including
  - the death of a spouse or dependent,
  - the birth or adoption (or placement for adoption) of your child, or
  - obtaining a legal guardianship of a child or foster child;
- a change in your, your spouse's, or your dependent's employment status, including
  - the termination or commencement of employment,
  - a commencement of or return from an unpaid leave of absence, or
  - a change in worksite;
- your dependent satisfying or ceasing to satisfy the definition of "dependent" under the applicable Qualified Benefit, including attainment of certain age or student status;
- your, your spouse's, or your dependent's change in their place of residence that affects coverage; or
- the commencement or termination of an adoption proceeding.

Other Applicable Events.

There are other situations which would permit you to change your election mid-year before the annual enrollment. Other applicable events which permit you to make a change include:

- Significant increase or decrease in the cost of the Plan;
- Significant reduction in coverage under the Plan that causes a loss of coverage;
- Addition of coverage option under the Plan;
• Change in coverage under another employer’s medical plan covering your spouse or dependent;

• Medical plan covering your spouse or dependent has a different plan year;

• Loss of other medical coverage sponsored by a governmental or educational institution; and

• Your, your spouse’s or your dependent’s eligibility for or loss of eligibility for Medicare or Medicaid.

Significant Change in Cost or Coverage.
This provision does not apply to Health Care Reimbursement Account elections.

• Significant Cost Increase or Decrease. If you elect to participate in the Plan and your cost for coverage under the Medical Plan, Dental Plan, Vision Plan, and/or Dependent Care Reimbursement Account significantly increases or decreases during the Plan Year, then you may make a corresponding increase or decrease in your premium payments.

If there is a significant cost increase, you can also revoke your existing election and elect to receive coverage, on a prospective basis, under another benefit option providing similar coverage (if available), or if not available, drop coverage entirely.

If there is a significant cost decrease, you may begin participating in the Plan and elect the coverage that significantly decreased in cost.

These changes will be allowed under the Dependent Care Reimbursement Account only if the cost change is required by a dependent care provider who is not your Relative.

• Coverage is Significantly Reduced (With a Loss of Coverage). If you, your spouse, or dependent have a significant reduction in coverage that results in a “loss of coverage,” then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or drop such coverage if no other benefit package option providing similar coverage is available under the Plan.

A "loss of coverage" means:

- elimination of a benefit package option,

- loss of all coverage due to hitting a lifetime or annual coverage limit,

- an HMO ceasing to be available where you reside,

- a substantial decrease in medical care providers under an option, such as a hospital ceasing to be a member of a preferred provider network or a substantial decrease in physicians in a preferred provider network, or

- any other fundamental loss of coverage as determined by the Administrator.

• Coverage is Significantly Reduced (Without a Loss of Coverage). If you, your spouse, or dependent have a significant reduction in coverage but not a "loss of coverage" (for example, a significant increase in deductible, copayment, or out-of-pocket limit), then you may cancel your election for coverage and elect to receive
coverage, on a prospective basis, under another coverage option providing similar coverage. Coverage under the Plan is "significantly reduced" only if there is an overall reduction in coverage provided under the Plan.

Addition or Significant Improvement of Benefit Plan Option Providing Similar Coverage.
This provision does not apply to Health Care Reimbursement Account elections.

If the University adds a new benefit plan option or other coverage option (or significantly improves an existing benefit option or other coverage option), you may cancel your existing option and elect the newly-added option or the significantly improved option providing similar coverage, on a prospective basis.

Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan.
This provision does not apply to Health Care Reimbursement Account elections.

You may make an election change that is on account of and corresponds with a change made under the plan of your spouse, former spouse, or dependent's employer if (i) the other plan permits participants to make an election change, or (ii) this Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

Loss of Coverage Under Governmental/Educational Group Health Plan.
This provision does not apply to Health Care Reimbursement Account elections.

You may make an election to add coverage under the Medical Plan, Dental Plan, or Vision Plan for you, your spouse or dependent if any of you lose coverage under any group medical coverage sponsored by a governmental or educational institution (including a State children's health insurance program, medical program of an Indian Tribal government, a state health benefits risk pool or a foreign government group health plan).

Special Enrollment.
This does not apply to Dependent Care Reimbursement Account elections.

If you or your spouse or dependent are entitled to HIPAA special enrollment under the Plan – due to the addition of a new dependent by adoption, placement for adoption, birth, or marriage – you may make a mid-year change to your election consistent with your change in enrollment by completing an election form within 31 days of the event.

The special enrollment period is extended to 60 days in the event that you, your spouse, or your dependent either:

- are covered under Medicaid or a state children's health insurance plan ("CHIP"), and lose that coverage due to a loss of eligibility for the coverage, or

- become eligible for premium assistance under Medicaid or CHIP with respect to the Medical Plan, Dental Plan or Vision Plan.

Entitlement to Medicare or Medicaid.
This does not apply to Dependent Care Reimbursement Account elections.

If you, your spouse, or your dependent are covered under the Plan and become entitled to coverage under Medicare or Medicaid (other than coverage solely under the Plan for distribution of pediatric vaccines), you may change your election to cancel or reduce coverage under the Plan for the affected person. If there is a loss of coverage under Medicare or Medicaid, you may elect to begin or increase coverage under the Plan for the affected person.

Court Order/Medical Child Support Order.
This does not apply to Dependent Care Reimbursement Account elections.

If you are subject to a judgment, decree, or order resulting from a divorce, legal or change in legal custody (including a qualified medical child support order), you may make a consistent change in your election to either: (i) cover the
child or (ii) cancel coverage of the child, as applicable.

Reduction in Hours of Service.
*This provision applies to Medical Plan coverage only.*

You may make an election to stop Medical Plan coverage for you, your spouse or dependent on a prospective basis if:

- your employment status with the University was reasonably expected to average at least 30 hours of service per week, and there has been a change in your employment status such that you will reasonably be expected to average less than 30 hours of service per week after the change, although you continue to be eligible for coverage under the Medical Plan, and

- you have enrolled or intend to enroll yourself and your spouse and dependents, if applicable, in another plan that provides minimum essential coverage that is effective no later than the day immediately following the last day that medical coverage is revoked.

A "qualified health plan" is a fully-insured health plan that has been certified to meet the criteria for certification in a marketplace and is offered by a health insurance issuer that is appropriately licensed to offer such coverage and meets certain other requirements under federal law. The University may require you to certify that you have enrolled or intend to enroll yourself and your spouse and dependents, if applicable, in the qualified health plan.

Effective Date of Coverage Changes.

Changes to your coverage will be effective as of the life event if you make a timely election within 31 days of the life event.

Changes to HSA Elections.

With respect to elections for HSAs only, if you are an HSA Eligible Employee, you may begin, increase, or decrease your contributions to the HSA at any time at any time. You may also terminate your contributions to the HSA at any time.

F. Failure to Make Employee Contributions.

Generally, coverage under the Plan will end if you do not make the required employee contributions for benefits elected under the Plan (except in the case of an unpaid FMLA leaves of absence). In this situation, you may not make a new benefit election under the Plan for the remaining portion of that Plan Year. If you want to again participate, you must wait until annual enrollment.
G. Administrator May Cancel or Revise Certain Elections.

The Administrator may adjust your elections to the extent that the adjustment is necessary to satisfy the requirements of the Code.

H. Irrevocability of Elections.

An election, once made, will generally remain in effect until the earliest of:

- the date you are no longer a Participant,
- the effective date of a new election,
- the end of the Plan Year,
- the date the Plan or the Qualified Benefit is terminated, or
- failure to make required employee contributions for benefits elected under the Plan.

Except as provided under the section titled Changes in Election During the Year, or as otherwise required by law, an election may be changed only as of the beginning of the Plan Year after the election is made.

I. COBRA/Retiree Medical Premiums.

Any contributions received by the University relating to COBRA coverage or a qualified medical child support order for purposes of coverage under the Medical Plan, Dental Plan or Vision Plan, or from a former employee of the University for retiree coverage under the Medical Plan or Dental Plan (referred to as "Special Participants"), will be made on an after-tax basis under this Plan.

Elections for such coverage will remain in place until the earliest of:

- the date the Plan ends,
- the date the underlying coverage ends or is exhausted for the Special Participant, or
- the date the Special Participant revokes or stops coverage or fails to make timely contributions for coverage.

While coverage is in force, the Special Participant may make changes in the coverage as allowed under the underlying coverage, but only if:

- the change is on account of a "change in status,"
- the change is necessary or appropriate as a result of the "change in status," pursuant to the COBRA continuation coverage requirements or a qualified medical child support order, as applicable, and
- the change is requested by the Special Participant within 31 days after the change in status (60 days in the event of a special enrollment event regarding eligibility under Medicaid or a state children's health insurance Program ("CHIP")), to be effective on the later of the status change or the request for the change.

HEALTH CARE REIMBURSEMENT ACCOUNT

A. Reimbursement Amounts.

If you choose to contribute to a Health Care Reimbursement Account, the maximum amount that you may elect to have credited to your Health Care Reimbursement Account for a Plan Year is $2,550, increased by cost-of-living adjustments from time to time. If both you and your spouse are Participants, you may each contribute up to $2,550, increased by cost-of-living adjustments from time to time, to your separate Accounts. The minimum annual amount that you must have credited to your Health Care Reimbursement Account is $120.

B. Crediting Your Account.

Your Health Care Reimbursement Account will be credited on each January 1 (or, if later, the effective date of your election), with the annualized amount you have elected for the Plan
Year. Any expenses paid out of your Health Care Reimbursement Account during the Plan Year will be reflected in your Health Care Reimbursement Account balance.

C. Qualifying Health Care Expenses for General Purpose Health Care Reimbursement Account.

"Qualifying Health Care Expenses" are certain medical, dental, or vision expenses that can be reimbursed out of your General Purpose Health Care Reimbursement Account for expenses you or your dependents have Incurred. For this purpose, your "dependents" include your spouse, your children until the end of the year in which they turn age 26, and other individuals who qualify as your tax dependents.

Qualifying Health Care Expenses generally include expenses which:

- are for "medical care" as defined under the Code,
- are not otherwise reimbursed or covered by insurance.

Qualifying Health Care Expenses do not include:

- any premium paid for health, dental or vision coverage;
- any premium paid for qualified long-term care services;
- coverage for any product which is advertised, marketed, or offered as long-term care insurance;
- expenses for which you or your dependents are reimbursed or entitled to reimbursement through insurance or otherwise (other than through your Health Care Reimbursement Account); or
- expenses Incurred for over the counter drugs unless the drug is insulin or is legally obtained with a physician's prescription.

You will only be reimbursed for Qualifying Health Care Expenses to the extent that you are legally obligated to pay for the expense.

Examples of Qualifying Health Care Expenses could include:

- custodial care expenses,
- hearing aids,
- coinsurance amounts,
- deductibles,
- amounts in excess of the maximums allowed by the Plan, and
- OTC drugs that are prescribed or are insulin.

Examples of expenses that cannot be reimbursed include (but are not limited to):

- charges that are not reasonable or customary
- certain cosmetic surgery,
- premiums for health coverage,
- travel expenses,
- fees for health clubs,
- vitamins,
- qualified long-term care services, and
- non-prescribed OTC drugs (other than insulin).

You should contact your Human Resources Management and Development for additional information and examples.

D. Qualifying Health Care Expenses for Limited Purpose Health Care Reimbursement Account

If you are enrolled in a HDHP under the Medical Plan, "Qualifying Health Care Expenses" are the same as set forth above for General Purpose Health Care Reimbursement Accounts, but are limited to dental or vision expense only. This means that no medical expenses will be reimbursed.
E. Ceasing to be a Participant with Respect to the Health Care Reimbursement Account.

If you stop being a Participant during a Plan Year, you will be entitled to reimbursements from your Health Care Reimbursement Account for Qualifying Health Care Expenses that were Incurred during the Plan Year but before you stopped being a Participant.

In addition, you will not be entitled to reimbursement of Qualifying Health Care Expenses for any dependent after the person is no longer a dependent.

F. Carryover of Unused Amounts in the Health Care Reimbursement Account

Beginning with the 2015 Plan year, if you have a balance remaining in your Health Care Reimbursement Account at the end of the Plan Year, an amount will be carried over to the immediately following Plan Year equal to the lesser of:

- $500 or
- the amount remaining in your Account after all of your Qualifying Health Care Expenses submitted during the Plan Year or within the related Run-Out Period have been reimbursed.

This amount is called the "available carryover amount." Any unused amounts in excess of $500 will be forfeited as provided under the section titled Forfeiture of Unused Amounts. The available carryover amount does not reduce the maximum amount that you may elect to have credit to your Health Care Reimbursement Account for a Plan Year.

The available carryover amount will be available to you after the Run-Out Period for the prior Plan Year to reimburse Qualifying Health Care Expenses Incurred in the current Plan Year in the same way that your current year's election may be used. For this purpose, what can be reimbursed as a "Qualifying Health Care Expense" depends on whether you are currently enrolled in non-HDHP coverage or HDHP coverage. If you are currently enrolled in HDHP coverage, regardless of whether or not you were enrolled in HDHP coverage during the prior year, your available carryover amount can be used only as a Limited Purpose Health Care Reimbursement Account (to reimburse dental and vision expenses only). This limitation does not apply, however, if you use your Account balance during the Run-Out Period for reimbursement of claims Incurred in the prior Program Year during which you were enrolled in non-HDHP coverage.

Your available carryover amount, if any, will generally carry forward year to year.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

A. Reimbursement Amounts.

The maximum amount that you may elect to have credited to your Dependent Care Reimbursement Account for any Plan Year is $5,000 (or $2,500 if you are married and do not file a joint federal income tax return for the year). The minimum annual amount that must be credited to your Dependent Care Reimbursement Account for any Plan Year is $120.

Regardless of your income tax filing status, the maximum amount that you may elect to have credited to your Dependent Care Reimbursement Account for any Plan Year cannot be more than your Earned Income for the year, or, if you are married, the actual or deemed Earned Income of your spouse for the year.

B. Crediting Your Account.

Your Dependent Care Reimbursement Account will be credited, as of each payroll date (not on an annual basis), with the amount you elected for the Plan Year. Any expenses paid out of your Dependent Care Reimbursement Account during the Plan Year or within the Grace Period will be reflected in your Dependent Care Reimbursement Account balance. No reimbursement of Dependent Care Expenses will exceed the balance of your Dependent Care
Reimbursement Account at the time of the reimbursement. If you do not have enough in your Account to pay for Dependent Care Expenses, those expenses will be held and will be reimbursed at a later date if there is a sufficient balance in your Dependent Care Reimbursement Account.

**Example:** Assume you elected to have $5,000 contributed to your Dependent Care Reimbursement Account for the January 1, 2016 – December 31, 2016 Plan Year. As of March 1, 2016 you have made salary reduction contributions of $833 (and have not applied for any reimbursements). Consequently, as of March 1, 2016 you may only file for reimbursement for up to $833 (the amount you have actually contributed to the Account).

**C. Dependent Care Expenses.**

"**Dependent Care Expenses**" are expenses that can be reimbursed out of your Dependent Care Reimbursement Account. To qualify as Dependent Care Expenses, the expenses must:

- allow you and your spouse to work, and
- be for the care of a Qualifying Individual.

You will not be entitled to reimbursements unless both you and your spouse work or your spouse is a full-time student or is mentally or physically unable to care for himself or herself.

Expenses will not be reimbursed as Dependent Care Expenses unless their main purpose is to assure the Qualifying Individual's well-being and protection.

**Examples of expenses that are not considered Dependent Care Expenses include, but are not limited to:**

- services outside your home, unless the services are for a Type A Qualifying Individual or a Type B Qualifying Individual who regularly spends at least 8 hours each day in your home,
- expenses for persons "related" to you,
- expenses by a dependent care center that does not comply with state law,
- services not required by your employment, such as baby sitters for leisure activity,
- overnight camps,
- care provided by a person you claim as a dependent on your federal income tax return,
- amounts paid for food, clothing or education,
- transportation expenses for a dependent care provider,
- care when you are on vacation, holiday, or sick leave, or
- custodial care.

When the expense Incurred includes expenses for other benefits that are incident to and an inseparable part of the care, the full amount of the expense is considered to be for such care.

**Examples of expenses that are considered Dependent Care Expenses include:**

- The full amount paid to a nursery school that a child is enrolled in is considered to be a Dependent Care Expense, even though the school also furnishes lunch and educational services.
- Educational expenses Incurred for a child in the first grade or higher are not treated as eligible Dependent Care Expenses.
- Child care provided by a housekeeper whose services include child care and house cleaning are covered.
- Services provided by a child care center are generally covered. The child care center must be a center that provides dependent care for more than six individuals (who do not live at the center on a regular basis during the year) and receives a fee for providing the services. Such centers must
comply with all applicable state and local laws and regulations.

See your Human Resources Management and Development for additional guidance for determining whether a particular expense qualifies as a Dependent Care Expense.

D. Ceasing to be a Participant with Respect to the Dependent Care Reimbursement Account.

If you stop being a Participant during a Plan Year or within the Grace Period, you will be entitled to reimbursements from your Account for Dependent Care Expenses that were Incurred before you stopped being a Participant, not to exceed the credit balance of the Dependent Care Reimbursement Account at the time you stopped being a Participant.

If you are a Participant on December 31 but terminate employment during the Grace Period, you will be a Participant during the Grace Period.

E. Tax Credit vs. Dependent Care Reimbursement.

You are provided a limited tax credit for Dependent Care Expenses. As a general rule, the amount of the tax credit is 35% of the Dependent Care Expenses, reduced (but not below 20%) by one percentage point for each $2,000 (or fraction thereof) by which your adjustable gross income for the taxable year exceeds $15,000. Participation in this Plan affects this credit because the dependent care credit is not available for non-taxable reimbursements that you receive from your Dependent Care Reimbursement Account under this Plan. Under certain circumstances, the credit would be more valuable than the tax savings provided under this Plan. Therefore, you may wish to consult with your tax adviser before making use of your Dependent Care Reimbursement Account.

F. Reports.

The Administrator or Claims Supervisor will give you a statement showing the amount of Dependent Care Expense reimbursements you received during any Plan Year by January 31 of the following year.

PROVISIONS APPLICABLE TO ALL REIMBURSEMENT ACCOUNTS

A. Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses.

You may request reimbursement of Qualifying Health Care Expenses Incurred during the Plan Year, and Dependent Care Expenses Incurred during the Plan Year or within the Grace Period, by either:

- submitting a written claim form to the Claims Supervisor, or
- using your Debit Card,

not later than the end of the Run-Out Period following the end of the Plan Year (and, for Dependent Care Expenses, the Grace Period) in which the expenses were Incurred. The claim for reimbursement may be made before or after you have paid the Qualifying Health Care Expense or the Dependent Care Expense, but not before the expense has been Incurred.

Written Claim Form. The written claim form must include, as applicable:

1. the amount, date, and nature of the Qualifying Health Care Expense or Dependent Care Expense;
2. the name of the person, organization, or entity to which the Qualifying Health Care Expense was or is to be paid;
3. the name, address, and taxpayer identification number of the person, entity or organization performing the services subject to Dependent Care Expense reimbursement;
4. the name of the person for whom the Qualifying Health Care Expense was Incurred and, if the person requesting the benefits is not you, the relationship of the person to you;

5. the name of the person for whom the Dependent Care Expense was Incurred and the relationship of the person to you;

6. a written statement (bill or invoice) from the individual delivering the service stating that the Qualifying Health Care Expense or Dependent Care Expense has been Incurred and the amount of the Expense;

7. a written statement that the Qualifying Health Care Expense or Dependent Care Expense has not been reimbursed and is not reimbursable under any other health Plan coverage (or if the Qualifying Health Care Expense or Dependent Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);

8. a written statement that you are legally obligated to pay for the Qualifying Health Care Expense or Dependent Care Expense; and

9. any other information reasonably requested by the Claims Supervisor.

You must also submit with the claim form all explanation of benefit statements, relevant bills, receipts, or other statements with respect to the expenses.

If you submit the claim form and documentation required and your request for reimbursement is approved, your claim will be paid. Reimbursements will be made at such times as the Administrator prescribes. The Plan will reimburse:

- claims for Qualifying Health Care Expenses Incurred during the Plan Year, that are submitted for reimbursement by the end of the Run-Out Period following the close of the Plan Year, and

- claims for Dependent Care Expenses Incurred during the Plan Year or within the Grace Period, that are submitted for reimbursement by the end of the Run-Out Period following the close of the Plan Year and the Grace Period, provided the amount of any reimbursement will not exceed the amount credited to your Accounts at the time of the reimbursement.

**Debit Card.** If you purchase prescribed OTC drugs using your Debit Card, you must still apply for reimbursement by submitting a written claim form and a copy of the prescription for the OTC drug.

All Debit Card claims require substantiation to ensure the expense was eligible under the Plan, unless the charge is for a copayment or a recurring expense or the charge is substantiated at the point of sale by the provider. All reimbursements requiring substantiation are considered conditional until substantiated. In the event a conditional claim is not substantiated or the University otherwise becomes aware of an improper payment using the Debit Card, the University or Claims Supervisor will notify you of the improper payment and request repayment.

In the event of an improper payment, the Claims Supervisor and/or University reserve the right to:

- deactivate your Debit Card until the amount of the improper payment is recovered;

- require repayment in the amount of the improper payment;

- withhold the amount of the improper payment from your pay;

- offset future reimbursements due under your Accounts; and/or

- handle as any other business debt.

If you use your Debit Card and the transaction is approved, the Administrator will automatically
debit your Account for Qualifying Health Care Expenses Incurred. Any dispute regarding a claim for reimbursement will be governed by the claims procedures under the Plan. See the section titled Claims Procedures.

B. Forfeiture of Unused Amounts.

Except as provided under the section titled Carryover of Unused Health Care Account Amounts, Federal law requires that the amount credited to your Accounts be used only to reimburse you for Qualifying Health Care Expenses or Dependent Care Expenses Incurred during the Plan Year or, for Dependent Care Expenses, within the Grace Period for which your election is applicable and only if you apply for reimbursement before the end of the Run-Out Period, with any balance remaining in your Accounts to be forfeited. In other words, if you do not use up the amounts in your Health Care Reimbursement Account or Dependent Care Reimbursement Account during the Plan Year and, for Dependent Care Expenses, the related Grace Period, and submit your Expenses for reimbursement by the end of the Run-Out Period, you will lose those amounts. Therefore, it is very important to be conservative when deciding how much you will contribute to these Accounts.

HEALTH SAVINGS ACCOUNTS

A. Eligibility.

If you are eligible to participate in an HSA account, you may elect to reduce your salary, on a pre-tax basis per payroll period, to pay for contributions to an HSA. You are responsible for verifying your eligibility to establish and contribute to an HSA. If you are enrolled in or are a participant in any medical plan other than a HDHP, you will not be eligible to open an HSA account.

You, and not the University, are solely responsible for complying with any applicable contribution limits in effect.

You are an HSA Eligible Employee if you meet all of the following criteria:

- you are a participant in a HDHP under the Medical Plan,
- you are not covered under any other health plan that is not a HDHP,
- you are not enrolled in Medicare benefits,
- you are not enrolled in a General Purpose Health Care Reimbursement Account,
- you are not claimed as a dependent on another individual's tax return, and
- you are not covered by a government or military health care plan (e.g., TRICARE).

An available carryover amount will not make you HSA ineligible if you are otherwise an HSA Eligible Employee.

B. Contribution Limits.

For the HSA, you can contribute up to $6,550 each plan year if you are married or $3,300 if you are single. You can contribute an additional $1,000 if you are age 55 or older. These limits are for 2015, and will change with cost of living each year.

C. HSA Eligible and Ineligible Expenses.

You can only use HSA dollars toward eligible expenses – those you pay for out of your own pocket for medical care that is provided to you, your spouse, and eligible tax dependents. IRS rules govern expense eligibility and, generally, these rules state that medical care includes items and services that are meant to diagnose, cure, mitigate, treat, or prevent illness or disease. Transportation that is primarily for medical care is also included.

Some examples of eligible expenses include:

- Your health plan deductible (the amount you pay before your plan starts paying a share of your costs);
- Your share of the cost for doctor’s office visits and prescriptions;
- Your share of the cost for eligible dental care, including exams, X-rays, cleanings and orthodontia; and

- Your share of the cost for eligible vision care, including exams, eyeglasses, contact lenses and laser eye surgery.

Expenses reimbursed under your HSA cannot be reimbursed under any other plan or program. Only your out-of-pocket health care expenses are eligible for reimbursement. Expenses reimbursed under an HSA cannot be deducted when you file your tax return.

Some examples of ineligible expenses include:

- Cosmetic surgery and procedures,
- Teeth whitening,
- Herbs, vitamins and supplements,
- Insurance premiums, and
- Family or marriage counseling.

D. HSA Portability.

You own your HSA and can keep it even when you terminate employment. Amounts in your HSA roll over from year to year and accumulate in your account. There is no "use it or lose" it rule with HSAs, and it can be used for eligible expenses now, in the future, or during retirement.

E. Debit Card.

You will be issued a debit card to use to pay for eligible expenses from your HSA.

COBRA COVERAGE

The following COBRA continuation provisions, along with the provisions under the section titled COBRA/Retiree Medical Premiums, apply with respect to your Health Care Reimbursement Account to the extent you have an account balance at the time of the qualifying event. Except as otherwise provided, the COBRA continuation provisions under the Employee Benefit Plan apply to the Plan.

A. Qualified Beneficiaries.

Only "qualified beneficiaries" may choose to continue coverage. You are a qualified beneficiary if you are covered under the Health Care Reimbursement Account on the day before a "qualifying event" and you are:

- an Eligible Employee who is covered under the Health Care Reimbursement Account (called a "covered employee");
- a spouse of a covered employee; or
- a dependent child of a covered employee (including dependents born to or placed for adoption with you during the continuation coverage).

B. Qualifying Events.

If one of the following "qualifying events" should occur that would cause you to "lose coverage" under the Health Care Reimbursement Account under the Plan, you have the right to choose to continue benefit coverage under the Health Care Reimbursement Account under the Plan through COBRA. You are considered to "lose coverage" if you cease to be covered under the same terms and conditions as in effect immediately before the qualifying event or have an increase in the premium or contribution that you must pay. These qualifying events are:

- your death;
- your termination of employment (other than by reason of gross misconduct) or reduction of hours that results in a termination of coverage under the applicable benefit feature;
- your divorce or legal separation;
- you becoming entitled to Medicare benefits under Social Security; or
- your child ceasing to be considered a dependent child as defined under the
Health Care Plan, Dental Plan, or Vision Plan.

C. Electing COBRA Coverage.

To obtain continuation coverage, each qualified beneficiary must elect it on a form provided by the Administrator or its designee. The period to elect COBRA benefits begins on the date the qualified beneficiary would lose coverage under the Health Care Reimbursement Account and ends 60 days after the later of:

- the date the qualified beneficiary would lose coverage due to the qualifying event; or

- the date the COBRA notice is sent by the Administrator or its designee.

The election form explains the terms and payments for coverage. Your election is considered to be made on the date you send the election form to the Administrator or its designee.

D. Paying for COBRA Coverage.

The qualified beneficiary is responsible for paying the monthly cost of continuation coverage. This cost is called a "premium." Premiums must be paid each month.

After a qualifying event, the qualified beneficiary will receive a notice specifying:

- the amount of the premium,

- to whom the premium is to be paid, and

- the date each monthly payment is due.

Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium (other than the initial one – see below) will be considered "timely" only if it is made within 31 days after the due date.

The initial premium payment, which is for the time period between the date of the qualifying event and the date you elected COBRA coverage, must be made within 45 days after the date of election. Failure to pay this initial premium by the due date will result in cancellation of coverage back to the initial date coverage would have been terminated.

E. Length of COBRA Coverage.

COBRA coverage in the Health Care Reimbursement Account will extend only until the end of the Plan Year in which the qualified beneficiary's qualifying event occurs.

F. When COBRA Continuation Coverage Ends.

COBRA continuation coverage will end earlier than the end of the Plan Year in which the qualifying event occurs if:

- COBRA premium payments are not made on a timely basis;

- the qualified beneficiary first becomes covered under any other group health Plan after electing COBRA coverage (if the other Plan contains a limitation with respect to any pre-existing condition that impacts the qualified beneficiary, coverage will not terminate);

- the qualified beneficiary first becomes entitled to benefits under Medicare after electing COBRA coverage; or

- the University ceases to provide any group health plan to any employee.

Coverage may also terminate "for cause" (e.g., the qualified beneficiary submits fraudulent claims). You will be notified, as soon as possible after your continuation coverage is terminating, if such coverage terminates prior to the maximum period set forth above.

G. Notification Requirements.

General Notification to Covered Employee and Spouse. The Plan will give written notice to you and your spouse of your rights to
continuation coverage. This notice will be provided to you and your spouse not later than the earlier of: (i) 90 days after your coverage begins, or (ii) the date you would otherwise receive an election form due to a qualifying event (see the section titled Administrator Notification to Qualified Beneficiary below).

University Notification to Claims Supervisor. In addition, the University will notify the Claims Supervisor in the event of your death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within 31 days after the date of the qualifying event.

Covered Employee/Qualified Beneficiary Notification to Administrator.

If you are a covered employee or a qualified beneficiary, you must notify the Administrator or its designee if (i) you divorce or legally separate from your spouse, (ii) a child ceases to be a dependent child, or (iii) you have a second qualifying event, as soon as possible, but no later than 60 days after the later of:

- the date of the qualifying event,
- the date the qualified beneficiary would lose coverage due to such qualifying event, or
- the date you are notified of your notice obligation.

Failure to provide notice within this time frame will result in the loss of your right to elect continuation coverage.

Procedures for Covered Employee/Qualified Beneficiary Notification.

Who Are the Individuals Required to Give Notice?

- The qualified beneficiary,
- The covered employee, or
- The representative acting on behalf of the covered employee or qualified beneficiary.

What Events Require Me to Give Notice?

- A divorce or legal separation of the covered employee from his or her spouse, or
- A child ceasing to be a dependent child under the eligibility requirements of the group health coverage.

How Am I to Give Notice? The notice that you are required to provide must be in writing and submitted on the form. Oral notice, including notice by telephone, is not acceptable. You must request (either in person, via telephone or e-mail) a copy of the form from the Administrator. You must complete the form (including any attachments described below) and then return the form and attachments (either by hand-delivery or mail) to the Administrator by the time period set forth in the section titled Covered Employee/Qualified Beneficiary Notification to Administrator above in order to receive COBRA continuation coverage. If mailed, the form must be postmarked no later than the last day of the required notice period (as set forth in the section titled Covered Employee/Qualified Beneficiary Notification to Administrator above) in order to receive COBRA continuation coverage.

If you do not complete and return this form within this required time period, no continuation coverage will be provided to you.

What Information Will I Need to Provide on the Form? On the form you must indicate the name of the Plan, the name and address of the covered employee under the Plan, the name(s) and address(es) of any qualified beneficiary(ies), the qualifying event, and the date of the qualifying event. If the qualifying event is a divorce, you must attach a copy of the divorce decree to the form. Your notice of disability determination or cessation must attach a copy of the Social Security Administration's determination.
Administrator Notification to Qualified Beneficiary. Upon notification of a qualifying event, you and your dependents will be notified by the Administrator or its designee of your right to elect continuation coverage within 14 days after the date the Administrator or its designee received notice of these qualifying events.

Unavailability of Coverage. In addition, if you are not entitled to receive continuation coverage, you will be notified of this and will be provided with an explanation as to why you are not entitled to this continuation coverage.

Notice of Termination of Coverage. The Administrator or its designee will notify you of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to your qualifying event, as soon as practicable following the Administrator's or its designee's determination that continuation coverage should terminate.

Any notification to a qualified beneficiary who is the spouse of the covered employee will be treated as a notification to all other qualified beneficiaries residing with the spouse when notification is made.

H. About the Coverage Provided Under COBRA.

The COBRA coverage provided will be identical to the coverage provided to similarly situated persons who have not experienced a qualifying event. If coverage is modified for any group of similarly situated beneficiaries, coverage will also be modified in the same manner for all qualified beneficiaries. Also, if an open enrollment period and/or an ability to add or eliminate family members is offered to active employees, the same options will be offered to qualified beneficiaries.

ADMINISTRATION OF THE PLAN

A. Administrator.

The Administrator may designate person, subcommittee, Claims Supervisor, or organization to perform certain responsibilities of the Administrator. The Administrator has the authority to control and manage the operation and administration of the Plan and is the named fiduciary of the Plan. Benefits under the Plan will be paid only if the Administrator, in its sole discretion, decides that the applicant is entitled to them.

The Administrator has the power and authority to determine all questions of law or fact that may arise as to eligibility, benefits, status and rights of any person claiming benefits or rights under the Plan, to construe and interpret the Plan consistent with the Code and ERISA, and to correct any defect, supply any omissions, or reconcile any inconsistencies in the Plan.

B. Claims Procedure.

Please see your Qualified Benefit Summaries for claims procedures applicable to those benefits. A brief summary of the claims process for the Plan is outlined below. All notifications for claim review, denial, approval and appeal may be done in writing or electronically, unless otherwise designated.

Whenever we refer to "you" in this Article, this will mean any claimant such as you, your spouse, or your dependent.

C. Claims for Health Care Reimbursement Account.

Initial Claim. Any claim to receive reimbursement for Qualifying Health Care Expenses must be filed with the Claims Supervisor, on behalf of the Administrator, not later than the end of the Run-Out Period after the end of the Plan Year in which the claim was Incurred.

You must submit with the claim relevant information as required under Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses.
Initial Review. When a claim has been properly filed, you will be notified of the approval or denial no later than 30 days after the Claims Supervisor receives the claim, unless the Claims Supervisor needs an extension of 15 days for reasons beyond the Claims Supervisor's control, in which case you will be notified of the extension before the end of the original 30-day period. If additional information is needed, you will have 45 days to provide the information. If you do not provide the information, the claim will be denied. Otherwise, the claim will be decided within 15 days of the Claims Supervisor receiving this information.

Initial Denial. If any claim for reimbursement is partially or wholly denied, you will be given a notice. The notice will include:

- the reasons for the denial;
- reference to the language from the Plan that supports the denial decision;
- a description of any additional information needed and why;
- a description of the review procedures and time limits;
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free upon request.

First Level Appeal of Claim Denial. You may initiate a first level of appeal of a claim denial by filing a written appeal with the Claims Supervisor or its designee within 180 days after receipt of the denial. If you do not file a timely first level of appeal, the Claims Supervisor's decision will be final and binding.

Decision on First Level of Appeal. You will receive notice of the Claims Supervisor's decision on the first level of appeal within 30 days after the Claims Supervisor receives the appeal. In addition, if your claim is denied on the first level of appeal, you will be given a notice with a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information relevant to your claim. The notice will also contain:

- the reasons for the denial;
- reference to the language from the Plan that supports the denial decision;
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free upon request.

If you do not file a timely second level of appeal, the Claims Supervisor's decision on the first level of appeal will be final and binding.

Second Level Appeal of Claim Denial. You may initiate a second level of appeal of a claim denial by filing a written appeal with the Administrator or its designee within 60 days after receipt of the denial. If you do not file a timely second level of appeal, the Claims Supervisor's decision on the first level of appeal will be final and binding.

Appeals of claims for reimbursement of Qualifying Health Care Expenses will be reviewed by the appropriate named fiduciary who will:

- not be the individual or subordinate of the individual who made the initial determination, and
• not give any weight to the initial determination.

In the case of two levels of appeal, the second level reviewer will not defer to the first level reviewer, nor will the second level reviewer be the same individual or the subordinate of the first level reviewer.

If any appeal is based, in whole or in part, on a medical judgement, the fiduciary will consult with an appropriate Health Care Professional who is neither the individual nor the subordinate of the individual who was consulted in connection with the initial determination. Any medical or vocational experts whose advice was obtained in connection with the appeal will be identified.

Decision on Second Level of Appeal. The Administrator or its designee will notify you of its decision on the second level of appeal within 30 days after the Administrator receives the appeal. In addition, if your claim is denied on the second level of appeal, you will be given a notice with a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain:

• the reasons for the denial;

• reference to the language from the Plan that supports the denial decision; and

• the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request.

The decision on the second level of appeal will be final and binding.

D. Claims for Dependent Care Reimbursement Account.

Initial Claim. Any claim to receive reimbursement of Dependent Care Expenses must be filed with the Claims Supervisor not later than the end of the Run-Out Period after the end of the Plan Year and Grace Period in which the claim was Incurred. You must submit with the claim relevant information as required under Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses on page 9.

Initial Review. When a claim has been properly filed, you will be notified of the approval or denial within 90 days after the claim is received, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be furnished to you before the end of the initial 90-day period, telling you the circumstances requiring an extension and when a final decision will be reached (which will be no later than 180 days after the claim was filed).

Initial Denial. If any claim for reimbursement is partially or wholly denied, you will be given a notice which will include:

• the reasons for the denial;

• reference to the language from the Plan that supports the denial decision;

• a description of any additional information needed and why; and

• a description of the review procedures and time limits.

Appeal of Claim Denial. You may appeal a claim denial by filing a written appeal with the Claims Supervisor or its designee within 60 days after you receive notification of the denial. If your request is not timely, the Claims Supervisor or its designee's decision will be final and binding.

Denial of Appeal. You will receive notice of the Claims Supervisor's or its designee's decision on appeal within 60 days after receipt of your appeal request, unless special circumstances require an extension of time to process the appeal. If so, the Claims Supervisor or its designee will notify you (i) of the extension and (ii) when a final decision will be reached (which will not be later than 120 days after receipt of such appeal).
If your claim appeal is denied, you will be given notice with a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain:

- the reasons for the denial; and
- reference to the language from the Plan that supports the denial decision.

A decision on review will be final and binding

E. Claims Provisions Applicable to Both Health Care Reimbursement and Dependent Care Reimbursement Accounts.

Authorized Representative. You may have a representative act on your behalf in pursuing a benefit claim or appeal.

Calculating Time Periods. Claims time periods will begin when a claim or appeal is filed, even if all necessary information is not with the filing. If you fail to provide certain needed information, these time periods may be put on hold. See the Administrator or the Claims Supervisor for details.

Full and Fair Review. You will have reasonable access to, and copies of, all documents, records, and other information relating to your claim, free of charge. You may submit written comments, documents, records, and other information relating to the claim.

If your review request is timely, the review of your denied claim will take into account all comments and documents you submitted about your claim even if that information was not submitted or considered in the initial benefit determination.

Mediation. Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, please contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Exhaustion of Remedies. If you fail to file a request for review of a denial of benefits in whole or in part, as required by these procedures, or fail to follow these procedures, you will have no right to review and no right to bring action, at law or in equity, in any court. The denial of the claim will become final and binding for all purposes

PROTECTED HEALTH INFORMATION

A. Your Protected Health Information

Federal privacy rules govern how the Plan may use and disclose your Protected Health Information and when it may be shared with the University. Protected Health Information ("PHI") generally means information (including demographic information) that:

- identifies an individual (or provides a reasonable basis to believe the information can be used to identify an individual);
- is created or received by a health care provider, a health plan, or certain other entities of the health care industry; and
- relates to the past, present, or future physical or mental health or condition of an individual; information regarding health care provided to an individual; or the past, present, or future payment for an individual's health care.

The Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and for other purposes relating to operating the Plan and providing benefits to you.

B. Disclosure of PHI to the University

PHI may need to be disclosed to the University from time to time. The Plan may:

- Disclose Summary Health Information to the University, if the University requests the Summary Health Information for the purpose of:
  - Obtaining premium bids from health
plans for providing health insurance coverage under the Plan; or

- Modifying, amending, or terminating the Plan.

"Summary Health Information" generally means health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the University has provided health benefits under a group health plan. However, identifiers (such as names, addresses, and social security numbers) that can directly link the health information to a particular individual are removed from the information.

- Disclose to the University information on whether you or your dependent(s) are participating in the Plan, or are enrolled in or have disenrolled from the Plan.

- Disclose PHI to the University to carry out Plan administration functions.

- With your authorization, disclose PHI to the University for purposes related to the administration of other employee benefit features and fringe benefits sponsored by the University.

In any event, the Program may not:

- Permit a health insurance issuer or HMO to disclose PHI to the University except as permitted by this Section;

- Disclose (and may not permit a health insurance issuer or HMO to disclose) PHI to the University unless a statement is included in the Plan's Notice of Privacy Practices that the Plan (or a health insurance issuer or HMO with respect to the Program) may disclose PHI to the University; or

- Disclose, without your authorization, PHI to the University for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit feature of the University.

C. Uses and Disclosures by the University

When the Plan gives the University your PHI, the University may not use or disclose PHI for employment-related decisions or for its other benefit features without authorization. The University may use and disclose PHI without your authorization for Plan administrative functions including payment activities and health care operations, or as required by law. If the University uses an agent or subcontractor to assist it in performing these activities, the agent's or subcontractor's use and disclosures of PHI will be limited in the same manner as those applicable to the University.

The University must report any known improper use or disclosure of PHI to the Plan. The University must also make its records available to federal regulators who are in charge of ensuring that the Plan is protecting your PHI. In addition, the University must also assist the Plan in administering rights that you have to your PHI as described in the Plan's notice of privacy practices. When the University no longer needs the PHI, it must destroy it or return it to the Plan. If return or destruction is not feasible, it must continue to maintain the PHI in accordance with this Article.

ADDITIONAL IMPORTANT INFORMATION

A. Assignments of Benefits.

Subject to the provisions of any applicable qualified medical child support order (described below), for your protection, you cannot assign your benefits under the Plan to anyone else. To the extent allowed by law, your benefits cannot be seized to pay your debts or satisfy other obligations you may have.

B. Qualified Medical Child Support Orders.

If the Plan receives a medical child support order, which is an order that provides for the right to receive benefits under the Plan for your children, then the Administrator will follow the
order as required by applicable law. The University will notify you and the individual who has a right to this benefit of:

- the receipt of the order,
- the procedures for determining if the order is a qualified medical child support order, and
- the decision as to whether the order is a qualified medical child support order.

You may obtain, without charge, a copy of the procedures from the Administrator.

C. Change or Termination of Plan.

It is hoped that this Plan will be continued indefinitely, but the University reserves the right to amend or terminate the Plan at any time.

D. Federal Income Tax Consequences.

Although the Administrator and the University intend for your pre-tax benefits to be excluded from income for federal, state, local income, and Social Security tax purposes, the Administrator and University do not make any commitment that such benefits will be excludable from your income. It is your obligation to determine if payments from the Plan are excludable from your income.

E. HIPAA.

The Plan will comply with the requirements under HIPAA including:

- the issuance of certificates of coverage,
- compliance with certain special enrollment periods,
- nondiscrimination benefits requirements, and
- privacy requirements (as described under Privacy below),

to the extent required and to the extent not otherwise inconsistent with the requirements under Code Section 125 and any regulations issued thereunder.

F. Privacy.

The Plan will comply with the requirements under HIPAA regarding the confidentiality and security of protected health information.

G. FMLA and USERRA.

The Plan will comply with the requirements under the FMLA and USERRA.

H. Genetic Information Nondiscrimination Act.

The Plan will comply with the Genetic Information Nondiscrimination Act.

I. Misrepresentation.

If you or your beneficiary make a misrepresentation in applying for coverage or benefits, your coverage and the coverage of your beneficiary will be null and void.

J. Right of Recovery.

If any payment is made under the Plan that should not have been made, the University, the Administrator, or the Claims Supervisor may collect the incorrect payment from the appropriate party. If such payment is made directly to you, the University, the Administrator, or the Claims Supervisor may deduct it when making future payments directly to you.

K. Nondiscrimination Rules.

The Plan will comply with the nondiscrimination rules to the extent required by Code Sections 105(h), 125, and 129.

L. Limitation of Rights.

Neither the establishment nor maintenance of this Plan will affect the rights of the University or an Eligible Employee in the Plan to continue or terminate the employment relationship at any
time or the employment status of such Eligible Employee.

M. Indemnification.

If you receive a reimbursement from your Accounts that is not either a Qualifying Health Care Expense or a Dependent Care Expense, you must indemnify and reimburse the University for any liability because of failure to withhold taxes, which amount will not exceed the taxes you would have owed had you received cash compensation.

N. Taxes or Penalties.

If any taxes or penalties are payable by the University, such taxes or penalties will be payable by you to the extent such taxes would have been originally payable by you.

O. Receipt and Release.

Any payments to you will be in satisfaction of your claim.

P. Incapacitation.

When you are under legal disability, or, in the University's opinion, are in any way incapacitated so you are unable to manage your affairs, the University may cause your benefits to be paid to your legal representative for your benefit.

Q. Participant Death.

In the event of your death, your spouse (or if none, your executor or administrator) may apply on your behalf for reimbursement of benefits under the Plan.

R. Eligibility for Medicaid Benefits.

Benefits will be paid in accordance with any assignment rights made by or on your behalf under Medicaid. For purposes of enrollment and eligibility, your or your dependent's eligibility for or receipt of Medicaid benefits will not be taken into account.

WHAT KEY DEFINITIONS DO I NEED TO KNOW?

Certain words and phrases used in this Summary have special meaning as described in this section.

Account means your Dependent Care Reimbursement Account which accounts for reimbursement of Dependent Care Expenses and/or your Health Care Reimbursement Account which accounts for reimbursement of Qualifying Health Care Expenses. A Health Care Reimbursement Account can be either a:

- **General Purpose Health Care Reimbursement Account**, which is the Account maintained under the Plan for any Participant (other than a Participant in an HSA) and who directs amounts to a General Purpose Health Reimbursement Account for reimbursement of Qualifying Health Care Expenses; or

- **Limited Purpose Health Care Reimbursement Account**, which is the Account maintained under the Plan for any Participant who is enrolled in a HDHP under the Medical Plan and who directs amounts to a Limited Purpose Health Reimbursement Account for reimbursement of dental and vision Qualifying Health Care Expenses only.

Administrator means the University and any other person or person to the extent that the University has delegated any of its responsibilities as Administrator to that person or persons.

Claims Supervisor means the person, firm, or company who provides technical or administrative services, including processing and payment of claims. The University may appoint or remove a Claims Supervisor with respect to the Plan.


Debit Card means the card available for point of service direct debiting of your Health Care
Reimbursement Account for Qualifying Health Care Expenses.

**Dental Plan** means the group dental plan maintained by the University, as amended from time to time.

**Dependent Care Expenses** means expenses reimbursed out of your Dependent Care Reimbursement Account that allow you and your spouse to work and that are for the care of a Qualifying Individual.

**Earned Income** means earned income as defined under Code Section 32(c)(2), excluding amounts you paid or Incurred for dependent care reimbursement under this Plan. If your spouse is a student or is physically or mentally incapable of caring for himself or herself and shares your household, your spouse is considered to have Earned Income of not less than:

- $250 per month if you have one Qualifying Individual, or
- $500 per month if you have two or more Qualifying Individuals.

**Eligible Employee** means an Employee eligible to participate in the Medical Plan.

**Employee** means any common law employee of the University.

**Employee Benefit Plan** means the Butler University Employee Benefit Plan, as amended.

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

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**Grace Period** means, with respect to the Dependent Care Reimbursement Account, the period of January 1 through March 15 following the end of a prior Plan Year.

**Health Savings Account** or **HSA** means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary that meets the requirements of Code Section 223(d).

**High Deductible Health Plan** or **HDHP** means an option under the Medical Plan or under any other health plan that meets the requirements of Code Section 223.

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

**Incurs** or **Incur** means the date on which care or services are provided, not the date you are billed or pay for the care or services.

**Medical Plan** means the group health plan maintained by the University, as amended from time to time.

**Participant** means an Eligible Employee who has begun participation under the Plan and has not subsequently become ineligible to participate.

**Plan** means the Butler University Flexible Spending Account Plan, as amended.

**Plan Year** means the 12 month period from January 1 to December 31.

**Qualified Benefit(s)** means the (i) Medical Plan, (ii) Dental Plan, and/or (iii) Vision Plan.

**Qualifying Health Care Expense** means certain medical, dental and vision expense that can be reimbursed out of your Health Care Reimbursement Account for expenses you or your dependents have Incurred. If you participate in a Limited Purpose Health Care Reimbursement Account, a "Qualifying Health Care Expense" is limited to a dental or vision expense only.

**Qualifying Individual** means:

- your "qualifying child" as defined in Code Section 152(a)(1) who is under age 13 and whom you can claim as a dependent for federal income tax purposes ("Type A Qualifying
Individual”), or

- your dependent (under Code Section 152 but not subsections (b)(1), (b)(2) and (d)(1)(B)) or spouse who is physically or mentally incapable of caring for himself or herself and who shares a household with you for more than ½ of the year ("Type B Qualifying Individual").

A child of divorced or separated parents is a Qualifying Individual of the custodial parent if:

- the child is in the custody of one or both parents more than ½ of the year,
- the child receives over ½ of his or her support from his or her parents, and
- the parents are legally divorced or separated.

Your child who is under age 13 or is physically or mentally incapable of caring for himself or herself may be deemed to be a Qualifying Individual even if the former spouse, and not you, may be entitled to claim a personal exemption deduction with respect to the child.

Relative means your son, daughter, descendant of a son or daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, father, mother, ancestor of a father or mother, stepfather, stepmother, nephew, niece, uncle, aunt, and in-laws.

Run-Out Period means, for purposes of submitting Dependent Care Reimbursement Account claims, the period that is 90 days from the end of the Plan Year for claims Incurred during either (i) the previous Plan Year or (ii) the 75-day Grace Period immediately following the end of the Plan Year. For purposes of submitting Health Care Reimbursement Account claims, the period is 90-days from the end of the Plan Years for claims Incurred during the previous Plan Year. Such claims will be adjudicated in accordance with all Plan provisions related to claims.

Special Participant means an individual who has elected coverage under the Plan in accordance with the provisions under the section titled COBRA/Retiree Medical Premiums.

University means Butler University.


Vision Plan means the group vision plan maintained by the University, as amended from time to time.

WHAT GENERAL INFORMATION ABOUT THE PLAN SHOULD I KNOW?

Name of Plan. The legal name of the Plan is the "Butler University Flexible Spending Account Plan."

Type of Plan. The Plan is a flexible benefit plan under Code Section 125, with compensation reduction contributions providing health care reimbursement and dependent care reimbursement for Eligible Employees and eligible dependents.

Effective Date. The Plan was most recently amended and restated in its entirety effective January 1, 2015.

Administrator. The Administrator for the Plan is Butler University. Service of legal process may be made on the Administrator at the above address.

Employer Identification Number and Plan Number. The employer identification number assigned by the Internal Revenue Service to the University is 35-0867977. The University has assigned Plan Number 501 to the Plan.

Plan Year. Records of the Plan are maintained on the 12-month period from January 1 to December 31.

Source of Financing. The Plan is financed through University and employee contributions in amounts to be determined pursuant to the
provisions of the Plan. Any premium or contribution requirements will be communicated to you. Please review your annual enrollment materials or contact the Human Resources Management and Development for specific contribution amounts.

Claims Supervisor: The Claims Supervisor under the Plan is AmeriFlex. The contact information for AmeriFlex is:

AmeriFlex  
302 Fellowship Road  
Suite 100  
Mount Laurel, NY 08054  
(888) 868-3539

Effective January 1, 2016, the Claims Supervisor under the Plan is Discovery Benefits. The contact information for Discovery Benefits is:

Discovery Benefits  
4321 20th Avenue SW  
Fargo, ND 58103  
866-451-3399

WHAT ARE MY RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")?

Your Rights Under the Plan. As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Duties Owed to Participants. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the University or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcement of Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. However, before you file suit, you must first complete all of the
claims procedures outlined in this Summary. If you do not follow these claims procedures accordingly, you will have no right to review and no right to bring action, at law or in equity, in any court, and the denial of the claim will become final and binding. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that the Plan fiduciary misuses the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Questions. If you have any questions about your Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.