

TRINITY UNIVERSITY
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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TRINITY UNIVERSITY FLEXIBLE BENEFITS PLAN

INTRODUCTION

We have amended the “flexible benefits plan” that we previously established for you and other eligible employees. Under the “flexible benefits plan” you are provided a Premium Expense Payment program, a Health Care Reimbursement program and a Dependent Care Assistance program. You will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the Plan will control. Also, if there is a conflict between an insurance contract and either the plan document or this summary plan description, the insurance contract will control.

I. ELIGIBILITY

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

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

2. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan as of your date of employment with us. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When Is My Entry Date?

You can join the Plan on the day you meet the eligibility requirements.

4. Which Employees Are Eligible?

Only employees whose customary employment, excluding overtime work, is considered to be at least one-half of full time, as such is determined by the Administrator. Faculty members, however, must be full-time faculty in order to be eligible to participate in the Plan.

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

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

II. OPERATION

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to federal income or social security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. Also, we will make additional employer contributions to the Plan that you may use to increase the amounts used to pay benefits. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction on your return.

III. CONTRIBUTIONS

1. How Much of My Pay May the Employer Redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. How Much Will the Employer Contribute Each Year?

We may contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution will be made on a pro rata basis during the year. If you elect not to participate, the Employer will not contribute to the Plan on your behalf.

3. How is My Compensation Measured Under Our Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

4. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the non-insured benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

5. When Must I Decide Which Accounts I Want to Use?

You are required by federal law to decide before the Plan Year begins, during the “election period.” You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

6. When Is the “Election Period” for Our Plan?

Your election period will start on the date you first meet the “eligibility requirements” and end 30 days after your “entry date.” (You should review Article I on Eligibility to better understand the terms “eligibility requirements” and “entry date.”)

7. May I Change My Elections?

Generally, you cannot change the elections you have made after entering the Plan. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a “change in status” and you make an election change that is consistent with the “change in status.” Currently, federal law considers the following events to be “changes in status”:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent.

- For the Dependent Care Assistance program, your dependent no longer meets the qualification to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a “change in status.” In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse’s, former spouse’s or dependent’s employer.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement program, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Assistance program if the cost change is imposed by a dependent care provider who is your relative.

IV. BENEFITS

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

a. Medical Reimbursement Account:

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the Health Care Reimbursement Plan. The Health Care Reimbursement Plan enables you to pay for expenses which are not covered by our medical plan and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. A list of covered expenses is available from the

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

The most that you can contribute to your Health Care Reimbursement Plan each Plan Year is \$5,000. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

b. Dependent Care Assistance Account:

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the dependent care expenses during the year. The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$200 for one dependent or \$400 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the

service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you.

c. Premium Expense Account:

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our self-funded medical plan.
- Group term life insurance premiums.
- Dental insurance premiums.
- Disability insurance premiums.
- Vision insurance premiums
- Hospital confinement insurance premiums
- Cancer insurance premiums for initial diagnosis
- Cancer insurance premiums for specified diseases
- Keystone Benefit Plan

This plan provides discounts on a variety of services if you or your dependents (anyone living in your household) use a Keystone plan provider. It includes discounts on 13 multi-care plan categories of care, such as:

- Dental Care
- Hearing Care
- Chiropractic Care
- Massage Therapy
- Fertility
- Prescription Drugs
- Veterinary Care

- Vision Care
- Mental Health Care
- Physical Therapy
- Alternative/Holistic Medicine
- Home Health Care
- Durable Medical Equipment

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

The Administrator may select suitable insurance contracts for use in providing these benefits, which policies will provide uniform benefits for all participants selecting these benefits. The rights and conditions with respect to the Benefits payable from such benefits, shall be determined from the insurance contract issued under each Benefit and shall be determined therefrom, and such contract shall be incorporated herein by reference.

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

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

V. BENEFIT PAYMENTS

1. When Will I Receive Payments From My Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding nor are they subject to social security taxes. You will only be reimbursed to the extent that there are sufficient funds in the Account to cover your request.

The provisions of the insurance contracts will control what benefits will be paid and when.

2. What Happens If I Don't Spend All Plan Contributions?

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

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. However, for the Health Care Reimbursement Plan, the expenses you incur during that lapse in coverage are not reimbursable and your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What Happens If I Terminate Employment?

If you leave our employ during the Plan Year participation in the Health Care Reimbursement Plan will cease, and no further salary redirection nor Employer contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses incurred prior to your date of termination.

If you leave our employ during the Plan Year, you will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of

employment. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate.

If you leave our employ during the Plan Year you will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

Under Federal law, if you, your spouse, and/or your covered dependents lose coverage under this Plan, then you, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees “on a typical business day” in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in b. and c. below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer’s plan (whether as an employee or otherwise, provided the other employer’s health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a “for cause” termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a “similarly situated” employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

- a. If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.
- b. Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the

following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

- c. Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

You can elect to continue your participation in the Health Care Reimbursement Plan for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Reimbursement Plan if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under this Health Care Reimbursement Plan. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to provide this benefit. When you terminate employment the Administrator will provide you with a notice regarding your right to continue coverage.

6. Will My Social Security Benefits Be Affected?

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

You can elect to continue your participation in the Health Care Reimbursement Plan for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Reimbursement Plan if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under this Health Care Reimbursement Plan. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to

provide this benefit. When you terminate employment the Administrator will provide you with a notice regarding your right to continue coverage.

VI. HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, “highly compensated employees” and “key employees” generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a “highly compensated employee” or a “key employee.”

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on “highly compensated employees” or “key employees” will apply. You will be notified of these limitations if you are affected.

VII. PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII. GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the plan

1. General Plan Information

Trinity University Insurance Premium Payment Plan is the name of the Plan.

Your Employer has assigned Plan Number 525 to your Plan.

The provisions of your amended Plan become effective on April 14, 2004. Your Plan was originally effective on June 1, 1987.

Your Plan’s records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on June 1st and ends on May 31st.

2. Employer Information

Your Employer's name, address, and identification number are:

Trinity University, One Trinity Place, San Antonio, Texas 78212, 74-1109633

3. Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Trinity University
One Trinity Place
San Antonio, Texas 78212
(210) 999-7507

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

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Trinity University, One Trinity Place, San Antonio, Texas 78212

5. Type of Administration

The type of Administration is Employer Administration.

IX. ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- a. examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, 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 Pension and Welfare Benefits Administration.

- b. obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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.

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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request 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.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file 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.

If you have any questions about the 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 the 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.

2. Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA amended ERISA, the Public Health Service Act, and the Internal Revenue Code to provide improved portability and continuity of health insurance coverage.

HIPAA addresses, among other things, credit for prior creditable health coverage and a process for providing certificates concerning prior coverage by a group plan or individual policy carrier, and also provides new rights to allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent.

With respect to certification of prior creditable coverage, the law now provides a guarantee that each individual will receive credit for prior coverage periods to reduce his or her pre-existing condition period under this Plan. This ensures that individuals and families receive proper credit for their prior coverage. A certification of prior creditable coverage must be provided to the Administrator and/or the Third Party Administrator.

The Employee's prior employer is responsible for issuing certificates to individuals and families covered under the prior employer's sponsored plan. In the case of individual policies, the individual policy carrier is responsible for issuing such certificate. The Administrator and/or the Third Party Administrator will assist in obtaining a certificate from any prior plan or individual policy carrier, if necessary.

HIPAA states that creditable coverage is to include another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare or a public health plan provided no more than 63 days have lapsed between coverage periods. Waiting Periods are not considered a lapse in coverage for purposes of HIPAA.

HIPAA also provides that Employees or Dependents who are otherwise eligible but not enrolled in the plan and who would be late enrollees may enroll during the special enrollment period, without penalty, when a change in family status or loss of other group coverage occurs. Employees or Dependents are allowed to enroll in a group plan within 31 days following:

1. A loss of eligibility for group coverage under another plan due to:
 - (a) legal separation;
 - (b) divorce;
 - (c) death;
 - (d) termination of employment;
 - (e) reduction in work hours;
 - (f) employer contributions toward coverage have terminated; or
 - (g) termination of COBRA continuation.

2. A change in family status due to:
 - (a) marriage;
 - (b) birth of a child; or
 - (c) adoption or placement for adoption of a child.

Persons who enroll under these special enrollment conditions are not considered late enrollees.

Effective April 14, 2004, the Plan conforms with the requirements of HIPAA by establishing the extent to which the Employer will receive, use, and/or disclose Protected Health Information (“PHI”).

The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals’ PHI to the Employer only to permit the Employer to carry out plan administration functions. The Plan (and any business associate acting on behalf of the Plan) may not, and may not permit the health insurance issuer or HMO to, disclose individuals’ PHI to the Employer for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer. The Employer will ensure that any agent(s), including a subcontractor, to whom it provides individuals’ PHI received from the Plan (or from the Plan’s health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Employer with respect to such PHI.

The Employer will make the PHI of the individual available to such individual for amendment upon request in accordance with HIPAA. The Employer will ensure that adequate separation is established and maintained between the Plan and the Employer as required by HIPAA.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Employer, if the Employer 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.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Employer.

The following employees of the Employer may be given access to individuals’ PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan:

1. President;
2. Vice Presidents;

3. Director of Human Resources;
4. Assistant Director of Human Resources;
5. Employee and Benefits Administrator;
6. Clerical Staff of Human Resources; and
7. Internal Auditor.

These individuals will have access to individuals' PHI solely to perform plan administration functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of the Plan.

The Plan and the Employer will comply with the privacy requirements of HIPAA, as amended.

X. WHAT IS THE PLAN'S CLAIMS PROCEDURE?

1. Submitting Claims

Notwithstanding any provisions hereof to the contrary, the following claims procedure provisions shall apply to claims filed under the Plan on or after January 1, 2003. Written notice and proof of an incurred claim should always be with the Administrator as soon as possible. Claims must be filed within twelve (12) months from the date of service to be covered by the Plan. Claims must be filed sooner in certain circumstances as discussed below. If it can be shown that it was not reasonably possible to submit the notice within this period and that notice was given as soon as possible, the claim will not be reduced or invalidated. If an individual's coverage under the Plan ceases, all claims incurred prior to termination of coverage must be filed within ninety (90) days after the termination of coverage or the claim will not be covered by the Plan. If the Plan is terminated, all claims incurred prior to the Plan termination must be received within ninety (90) days after the termination or the claims will not be covered. Any claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

2. Notice of Failure to Follow Procedures

If a Plan Participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan Participant must be notified of this within 5 days. Notification may be oral or written.

3. Timing of Notification of Benefit Determination

The Administrator must notify the Plan Participant of an adverse benefit determination within 90 days after receipt of the claim, unless the Administrator

determines that special circumstances require an extension of time for processing the claim.

4. Manner and Content of Notification of Benefit Determination

The Administrator must provide the Plan Participant with written or electronic notification of an adverse benefit determination. The notification must set forth, in a manner calculated to be understood by the Plan Participant:

- a. the specific reason for the adverse determination;
- b. reference to the specific plan provisions on which the determination is based;
- c. a description of any additional material or information necessary for the Plan Participant to perfect the claim and an explanation of why such material or information is necessary; and
- d. a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Plan Participant's right to bring a civil action under Section 502 of ERISA following an adverse decision on appeal.

5. Appeal of Adverse Benefit Determination

Plan Participants may appeal an adverse benefit determination within 180 days. The appeal must be filed with the Administrator, who will forward the appeal to the Appeals Administrator. The appeal will be decided by the Appeals Administrator. In the case of a claim involving urgent care, a Plan Participant may request an expedited appeal orally or in writing.

6. Timing of Notification of Appeal Decision

In all other cases, the Plan Participant must be notified of the appeal decision within 60 days, unless the Appeals Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim.

7. Manner and Content of Notification of Appeal Decision

The Appeals Administrator must provide a Plan Participant with written or electronic notification of the appeal decision. In the case of an adverse appeal decision, the notification must set forth, in a manner calculated to be understood by the Plan Participant:

- a. the specific reason for the adverse decision;
- b. reference to the specific plan provisions on which the appeal decision is based;

- c. a statement that the Plan Participant 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 Plan Participant's claim for benefits; and
- d. a statement of Plan Participant's right to bring an action under Section 502(a) of ERISA.

If the Plan Participant's appeal is denied by the Appeals Administrator, the Plan Participant may file suit in Federal District Court.

This is a summary of the claims and appeals provisions of the Plan. Additional rules and requirements are set forth in the plan document.

XI. SUMMARY

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

If you have any questions, please contact the Administrator.