

MOUNT ST. MARY'S UNIVERSITY

HEALTH FLEXIBLE SPENDING ARRANGEMENT
DEPENDENT CARE ASSISTANCE PLAN

Effective January 1, 2008

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ARTICLE I
INTRODUCTION

Mount St. Mary's University hereby establishes a ("Plan") for its Employees to enable them to pay for certain healthcare expenditures and/or certain types of dependent care expenses from pre-tax accounts. This Plan is intended to qualify as a self-insured medical reimbursement plan under section 105 of the IRS Code of 1986 as amended and a dependent care assistance program under section 129 of the Code. The Plan shall be construed and interpreted in a manner that is consistent with the requirements of these sections and any implementing regulations. The Plan has two components: (i) a Health Flexible Spending Arrangement, ("Health FSA") which permits an employee to pay for qualifying medical expenses that are not otherwise reimbursable by insurance with pre-tax dollars, and (ii) a Dependent Care Assistance Plan ("DCAP"), which permits an employee to pay for his or her qualifying dependent care expenses with pre-tax dollars. A Health FSA is a welfare plan under ERISA. With respect to the Health FSA, this document is also intended to comply with the Summary Plan Description requirements under ERISA sec. 102, and implementing regulations under 29 C.F.R. sec. 2520.102-3. Mount St. Mary's University expects to continue the Plan but reserves the right to amend or terminate it at any time and for any reason.

Although reprinted within this document, the Health FSA and DCAP components are separate plans for purposes of administration and all non-discrimination and reporting requirements imposed by Code § 105 and Code § 129. The Health FSA component is a separate plan for purposes of applicable provisions of ERISA and COBRA.

Special rules apply to the types of expenses eligible for reimbursement under this Plan. This booklet provides guidelines for using the Plan and lists some of the eligible expenses.

ARTICLE II
ADMINISTRATIVE INFORMATION

Plan Name Mount St. Mary's University
Health Flexible Spending Arrangement and
Dependent Care Assistance Plan

Type of Plan The Health FSA only is a Welfare Benefit Plan (Group Health
Plan) subject to ERISA

The Plan Sponsor Mount St. Mary's University
16300 Old Emmitsburg Road
Emmitsburg, MD 21727
301-447-5372

Employer ID (EIN) 52-0591672

Plan Administrator Mount St. Mary's University
16300 Old Emmitsburg Road
Emmitsburg, MD 21727
301-447-5372

**The Agent for Service of
Legal Process** Mount St. Mary's University

16300 Old Emmitsburg Road
Emmitsburg, MD 21727
301-447-5372

In addition, service of legal process may be made upon the Plan
Administrator.

Plan Number 506

Plan Year Each Plan Year lasts for 12 months from January 1 to December
31.

Type of Funding Benefits under the Plan are funded exclusively by Employee
contributions, and paid from the Employer's general assets as
described in Article VII. Employees contribute at a fixed rate per
month toward the cost of the Plan through payroll deductions as
specified in the Election Form.

2.1 Assignment of Duties

- (a) The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the Plan. The Plan Administrator has the exclusive right and discretion to interpret the Plan and to

determine all questions of fact and/or law that may arise in connection with the administration of the Plan.

- (b) The Plan Administrator may assign its duties to others. The Plan Administrator has designated ConnectYourCare, LLC at 307 International Circle, Suite 200, Hunt Valley, Maryland 21030 the “Claims Administrator.” The function of claims administration, in accordance with the terms of the Plan documentation, has been assigned to the Claims Administrator.

2.2 Future of the Plan

The Employer intends to continue this Plan indefinitely. However, the Employer reserves the right to change or terminate the Plan at any time without Your consent or the consent of Your Spouse or Dependents. The Employer or any authorized officer or representative of the Employer can make changes to or terminate the Plan. You will be notified if any changes are made. Nothing in this Plan is intended to entitle You to vested benefits.

2.3 Not an Employment Contract

Neither this Plan nor any action taken with respect to it will confer upon any person the right to continue employment with Employer.

ARTICLE III DEFINITIONS

In this document, there are some words and phrases that have specific meanings within the context of the Plan. To help the reader understand these words, they are defined here and capitalized in this document.

- 3.1 **Account** means the Health FSA and DCAP accounts described herein.
- 3.2 **Cardholder Agreement** means the agreement that governs the use of an electronic payment card.
- 3.3 **Change in Status** has the meaning described in Article V.
- 3.4 **Claims Administrator** means ConnectYourCare, LLC and any business partners working on behalf of ConnectYourCare, LLC.
- 3.5 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended
- 3.6 **Code** means the Internal Revenue Code of 1986, as amended.
- 3.7 **DCAP** means dependent care assistance Flexible Spending Account program as described in Article IX.

- 3.8 **Dependent** means any individual who is a citizen or national of the United States or a resident of the United States or a country contiguous to the United States and is either a Qualifying Child or a Qualifying Relative as defined in Code § 152 and listed below with the following exceptions:
- (a) Notwithstanding the forgoing, the Health FSA will provide benefits in accordance with any Qualified Medical Child Support Order, even if the child does not meet the definition of “Dependent;” and
 - (b) For the Health FSA a Qualifying Relative is determined as defined in Code § 152 without regard to requirement in Code § 152(d)(1)(B) that the person have gross income less than the exemption amount in Code § 151(d).
- 3.9 **Earned Income** means all income derived from wages, salaries, tips, self-employment and other compensation included in gross income for the taxable year.
- 3.10 **Election Form** means the form that the Employer provides to the Eligible Employee to elect benefits under the Plan and specify salary reduction amounts. This form may be delivered and completed online.
- 3.11 **Eligible Employee** means an Employee who satisfies the requirements of Article IV.
- 3.12 **Employee** means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include any of the following:
- (a) Any leased employee or anyone classified by the Employer as a contract worker, independent contractor or temporary employee, whether or not such employee is on the Employer’s W-2 payroll;
 - (b) Any individual who performs services for the Employer but is paid by a temporary or other staffing agency;
 - (c) Any employee covered under a collective bargaining agreement;
 - (d) Any self-employed individual;
 - (e) Any partner in a partnership;
 - (f) Any more than 2% shareholder in a Subchapter S corporation.

Because you are an Employee of the Employer, this document will refer directly to “You” as an “Employee.”

- 3.13 **Employer** means Mount St. Mary’s University and any related employer that adopts this Plan with the approval of Mount St. Mary’s University.
- 3.14 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- 3.15 **Fiduciary** means a person who has discretionary authority over the administration of the Plan within the meaning of ERISA section 3(21).
- 3.16 **Flexible Spending Account** means the Health FSA and DCAP Plan.
- 3.17 **FMLA** means the Family and Medical Leave Act of 1993, as amended.

- 3.18 **Health FSA** means Health Flexible Spending Account as described in Article VIII.
- 3.19 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, as amended.
- 3.20 **Incurred** means the date the service, care or product giving rise to an expense has been furnished without regard to the date when the Participant is formally billed for, is charged with, or pays for the service, care or product.
- 3.21 **Medical Expense** means medical care expenses as defined under Code section 213(d) that are Incurred by You, Your Spouse and Dependents, which include, but are not limited to, medical expenses listed under 5.2(d).
- 3.22 **Named Fiduciary** means a named fiduciary within the meaning of ERISA section 402(a)(2) and listed in Section 7.3.
- 3.23 **Participant** means a person who is an Eligible Employee and who is participating in this Plan. Because you are a Participant in this Plan, this document will refer directly to “You” as a “Participant.”
- 3.24 **Plan** means the Mount St. Mary’s University Health Flexible Spending Arrangement and Dependent Care Assistance Plan, as described herein and as amended from time to time.
- 3.25 **Qualifying Child** under this Plan means an individual who (1) is the son, daughter, stepson, stepdaughter or eligible foster child of the Employee or a descendant of any such child, a sibling or step-sibling of the Employee or a descendant of any such relative; (2) has the same principal abode as the Employee for more than half the year; (3) is under age 19 as of the end of the calendar year, is a full-time student under age 24 at the end of the calendar year, or is permanently and totally disabled; and (4) has not provided more than half of his own support for the year.
- 3.26 **Qualifying Individual** has the meaning described in Article IX.
- 3.27 **Qualifying Relative** under this Plan is an individual who
- (a) Is the son, daughter, stepson, stepdaughter or eligible foster child of the Employee;
 - (b) For the DCAP only, has gross income less than the exemption amount in Code § 151(d);
 - (c) Receives over half of his support from the Employee; and
 - (d) Is not anyone else’s Qualifying Child.
- 3.28 **Spouse** means an individual who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code.

ARTICLE IV
ELIGIBILITY TO PARTICIPATE

4.1 Participation

You may elect to participate in the Plan as of the date You meet the criteria, including eligibility requirements and waiting periods, if any, to participate in any group medical plan offered by the Employer, regardless of Your actual enrollment in the group medical plan. Once You have met the eligibility criteria specified in the group medical plan, You are an Eligible Employee. An Eligible Employee may elect coverage the first day of the calendar month following the date that You became an Eligible Employee, or the first day of any subsequent Plan Year in accordance with the annual enrollment period described in Article V, provided that an Election Form is submitted to the Plan Administrator before the first day participation will commence. [or other rules that may apply]

4.2 Qualified Medical Child Support Order.

A Qualified Medical Child Support Order (“QMCSO”) is a type of order that is issued: (i) by a court of competent jurisdiction, or (ii) through an administrative process established under state law and which has the force and effect of law under applicable state law. The order is usually issued as part of a settlement agreement or divorce decree that provides for child support or health care coverage for Your child. The Plan Administrator will establish requirements for honoring a QMCSO.

ARTICLE V **ELECTIONS**

5.1 Period of Coverage; Election Form Generally Irrevocable.

Subject to Section 5.4, the election specified on Your Election Form is irrevocable during the Plan Year, except as provided in Sections 5.3 through 5.5.

5.2 Limits on Salary Reduction Amounts Elected.

The limits on salary reduction amounts that You may elect on an Election Form are as follows:

- (a) Health FSA. You may elect to salary reduce under the Health FSA for the Plan Year, the maximum amount is \$2,500.
- (b) Dependent Care FSA. You may elect to salary reduce under the DCAP for the Plan Year, the maximum amount is \$5,000.

5.3 Annual Enrollment Period

An annual enrollment period will be scheduled by the Employer prior to the beginning of each Plan Year. At that time, You will receive enrollment instructions describing the Accounts.

In order to participate in the Plan, You must complete an Election Form, specifying the total amount of Your annual compensation that You wish to reduce on a pre-tax basis each Plan Year

to apply toward the Accounts. The amount You elect to reduce will be deducted prorated (in equal amounts) from Your salary beginning the first payday of the Plan Year. An Election Form must be returned to the Plan Administrator on or before the last day of the annual enrollment period, and it will become effective on the first day of the next Plan Year.

If You do not become an Eligible Employee until after the first day of a Plan Year, You may file an Election Form with the Plan Administrator during the 30-day period following the first day on which You become an Eligible Employee. The Plan Administrator will provide You an Election Form at the time Your employment commences or as soon as administratively feasible after You become Eligible Employees.

5.4 Change in Election

Treasury Regulations require that generally, Your election must remain the same for the entire Plan Year. However, the regulations provide that You will be allowed to change Your election if the change is “on account of and corresponds with” a Change in Status event that affects eligibility for coverage under the Plan. The determination of whether a requested change is “on account of and corresponds with” a Change in Status event will be made by the Plan Administrator in accordance with the Plan Administrator's interpretation of the applicable regulations.

To change an election, You must complete and return an Election Form to the Plan Administrator within 30 days of the occurrence of the Change in Status event. Notwithstanding the foregoing, a Change in Status that results in a person becoming ineligible for coverage under the Plan will automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(a) Change in Status Events: Valid Change in Status Events consist of the following:

- Change in Your Legal Marital Status: marriage, divorce, annulment, legal separation or death of spouse;
- Change in Number of Dependents: events that change Your number of Dependents, such as birth, adoption, placement for adoption or death;
- Change in Employment Status of You, Your Spouse or Dependent: any of the following that change the employment status of You, Your Spouse, or Your Dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite that also affects benefit eligibility, or a change from an eligible to an ineligible employment status or classification;
- Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements: events that cause Your Dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, student status, or similar circumstances;

(b) Other Events That May Allow Changes under the Health FSA

- Judgment, Decree, or Order. If a judgment, decree, or order (collectively called “order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act) requires You to cover a child under the Employer's Health FSA, You may increase salary reduction amounts to cover eligible expenses of the child. Likewise, if the order requires another individual to provide coverage for the child, You may reduce salary reduction amounts.
- Medicare and Medicaid. If You, Your Spouse, or Dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), You may make a change to reduce salary reduction amounts for coverage under the Health FSA to take into account Medicare or Medicaid. Likewise, if You, Your Spouse, or Dependent loses eligibility for coverage under Medicare or Medicaid, You may increase salary reduction amounts for Health FSA to take into account loss of that coverage.
- Special requirements relating to the Family and Medical Leave Act. If You take leave under the Family and Medical Leave Act (FMLA), You may revoke an existing election under the Health FSA and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA. If You cease salary reduction for the Health FSA during FMLA leave and do not make after-tax payments during the period of FMLA leave to continue coverage, You will not be considered a Participant in the Plan, and You will not receive reimbursement for expenses Incurred during the time You were not a Participant. When You return from FMLA leave, You can elect to be reinstated in the Health FSA on the same terms as existed prior to the FMLA leave (unless those terms were changed in the meantime for other Plan Participants).

5.5 Changes Required for Non-discrimination Compliance

The Plan Administrator retains the authority to modify or revoke Your election without Your consent if the Plan Administrator deems it necessary in order to comply with non-discrimination rules under the Code.

ARTICLE VI **TERMINATION OF PARTICIPATION**

Participation will terminate on the earliest of:

- (a) The date You cease to be an Employee, except as otherwise allowed under COBRA coverage;
- (b) The date You cease to meet the criteria for eligibility to participate in any group medical plan offered by Employer;
- (c) The date the Plan is terminated or amended to exclude You;
- (d) The date of Your election not to participate during the Annual Enrollment Period or due to a Change in Status.

ARTICLE VII
BENEFITS

Benefits from the Health FSA and DCAP are paid from the Employer's general assets. There is no trust or other fund, no independent source of funds, or any insurance contract that guarantees the payment of benefits. For administrative convenience, the Claims Administrator processes all claims for reimbursements on behalf of Employer.

ARTICLE VIII
HEALTH FSA BENEFITS

8.1 Contributions

You contribute to the Plan through pre-tax dollars. You select the amount of Your contributions, up to authorized limits.

8.2 Reimbursements Under the Plan

- (a) Reimbursements shall only be made for Medical Expenses Incurred by You, Your Spouse and Dependents. Each Medical Expense must be substantiated by You, Your Spouse and Dependents in accordance with Section 10.2.
- (b) Medical Expenses that may be reimbursed under this Plan include, but are not limited to:
- (1) The diagnosis, cure, mitigation, treatment, or prevention of any disease, or for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to obtaining medical care; and
 - (3) Over-the-counter drugs and medications (e.g., pain reliever, antacid, allergy medicine, and cold medicine).

A partial listing of examples of eligible expenses includes the following:

- Alcohol or chemical dependency treatment
- Cosmetic surgery that is medically necessary (e.g., to cure deformity that is the result of an accident)
- Dental expense, including routine and preventive care
- Diabetic supplies, including insulin and testing strips
- Disability supplies, such as a guide dog
- Hearing aids, including batteries and repairs
- Medical equipment
- Mental health services (excluding marriage and family counseling)
- Over-the-counter medication, including antacid, allergy medication, pain reliever and cold medicine
- Physical, speech or occupational therapy

- Physician services, including surgeons, acupuncturists, chiropractors and other medical providers
- Prescription drugs
- Smoking cessation program
- Weight loss program
- Vision care, including exam, prescription glasses and contact lenses and supplies
- Vision correction surgery, such as RK or lasik

(c) Not all medical expenses are eligible for reimbursement under this Plan. Reimbursements under this Plan may not be made for:

- (1) Long-term care services as defined under Code section 7702B;
- (2) Premiums for healthcare or long-term care insurance;
- (3) Expenses incurred for cosmetic purposes;
- (4) A Medical Expense that is:
 - (A) Attributable to a deduction allowed under Code section 213 for any prior taxable year;
 - (B) Incurred before the effective date of this Plan;
 - (C) Incurred before You are a Participant in this Plan; or
 - (D) Reimbursed by another group health plan.

Here are some examples of expenses not eligible for reimbursement:

- Cosmetic expenditures (for example, teeth whitening, chemical peels)
- General wellness expenses (for example, health club dues, special foods and dietary supplements, vitamins, exercise programs and equipment)
- Insurance premiums
- Long term care expenses
- Other charges: missed appointment, late payment or interest charges

(d) If any unused amounts remain in Your FSA Account at the end of any Plan Year, You will forfeit to Your Employer any unused balance that remains on the date that the deadline for filing claims expires.

(e) The annual amount elected for the Plan Year minus any amounts already reimbursed will be available at all times during the Plan Year while You are covered under the Plan, regardless of the actual amounts deposited to Your Health FSA.

8.3 Termination of Employment.

(a) Coverage under this Plan shall cease upon termination from employment. However, You may submit claims for reimbursement for Medical Expenses arising before the termination date in accordance with Article X.

- (b) Unless a COBRA election is made, You, Your Spouse or Dependents shall not be entitled to receive reimbursement for Medical Expenses Incurred after coverage ceases under this Plan.
- (c) Any unused amounts held in Your FSA Account shall be forfeited and returned to the Employer.

8.4 Repayment of Excess Reimbursements.

If it is determined that You have received payments under this Plan that exceed the amount of Medical Expenses that have been substantiated by You during the Plan Year, the Plan Administrator shall give You prompt written notice of any such excess amount, and You shall repay the amount of such excess to the Employer in accordance with procedures established by the Plan Administrator. If repayment is not made, the Plan Administrator shall direct the Employer to withhold such excess reimbursement from Your compensation. If that is not successful, the Plan Administrator may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement are unsuccessful, the Plan Administrator may direct the Employer to include such amounts in Your gross income.

8.5 Subrogation.

- (a) The Plan is entitled to recover the cost of any benefits it has provided under this Plan for You, Your Spouse and Dependents as a result of an injury caused by a third party out of the proceeds of any judgment or settlement that You, Your Spouse and Dependents receive from the third party, the third party's insurer, or from any insurer providing You, Your Spouse and Dependents with indemnity against the acts of third parties. The Plan may recover any amounts owed to it either from third-party funds received by You, Your Spouse and Dependents, regardless of whether You, Your Spouse and Dependents have been fully indemnified for losses sustained at the hands of the third party, or the Plan may pursue its recovery rights in the place of You, Your Spouse and Dependents as subrogee against the third party.
- (b) You, Your Spouse and Dependents must notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that may be subject to subrogation by the Plan. You, Your Spouse and Dependents also must keep the Administrator informed in advance of any settlement proposals advanced or agreed to by the third party or the third party's insurer.

ARTICLE IX **DEPENDENT CARE ASSISTANCE FSA BENEFITS**

9.1 Contributions

You contribute to the Plan through pre-tax dollars. You select the amount of Your contributions, up to authorized limits. The maximum annual benefit amount You can deposit into Your DCAP each Plan Year cannot exceed the statutory limit.

9.2 Qualifying Individual

A “Qualifying Individual” under the DCAP Plan means a person who has the same principal place of abode as You for more than one-half the year and is one of the following:

- (a) Your Dependent who is under age 13;
- (b) Your Dependent who is mentally or physically incapable of self-care and has gross income of less than the exemption amount under Code section 151(d); or
- (c) Your Spouse who is mentally or physically incapable of self-care care and has gross income of less than the exemption amount under Code section 151(d).

In the case of divorced parents, a Qualifying Individual who is a child will be treated as the Qualifying Individual of the custodial parent and will not be treated as a Qualifying Individual of the non-custodial parent. If the parents share custody and the child is in the custody of both parents for more than one-half the year, the child is treated as having been in the custody of the parent who had custody for the greater portion of that year.

9.3 Reimbursements Under the Plan

- (a) Reimbursements shall only be made for eligible dependent care expenses that relate to the care of a “Qualifying Individual” that enable You and Your Spouse to remain gainfully employed and are Incurred during the Plan Year while covered under the Plan and cannot be reimbursed through any other arrangement. Each dependent care expense must be substantiated by You in accordance with Article X.

A partial listing of examples of eligible expenses includes the following:

- Au pair services
 - After-school care
 - Before-school care
 - Dependent care center
 - Nursery school
- (b) Not all dependent care expenses are eligible for reimbursement from the DCAP. Eligible dependent care expenses do not include amounts paid to Your Spouse or Your child who is under age 19. Here are some examples of other expenses not eligible for reimbursement:
 - Housekeeping services separate from child care duties
 - Kindergarten
 - Medical care
 - Overnight camps

- (c) If any unused amounts remain in Your DCAP at the end of any Plan Year, You will forfeit to Your Employer any unused balance that remains on the date that the deadline for filing claims expires.
- (d) The maximum amount of reimbursement under this Plan during the Plan Year shall not exceed the amount credited and currently held in Your DCAP.

9.4 Termination of Employment.

- (a) Coverage under this Plan shall cease upon termination from employment. However, You may submit claims for reimbursement for expenses arising before the termination date in accordance with Article X.
- (b) You shall not be entitled to receive reimbursement for expenses Incurred after coverage ceases under this Plan.
- (c) Any unused amounts held in Your DCAP shall be forfeited and returned to the Employer.

9.5 Repayment of Excess Reimbursements.

If it is determined that You have received payments under this Plan that exceed the amount of dependent care expenses that have been substantiated by You during the Plan Year, the Plan Administrator shall give You prompt written notice of any such excess amount, and You shall repay the amount of such excess to the Employer in accordance with procedures established by the Plan Administrator. If repayment is not made, the Plan Administrator shall direct the Employer to withhold such excess reimbursement from Your compensation. If that is not successful, the Plan Administrator may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement are unsuccessful, the Plan Administrator may direct the Employer to include such amounts in Your gross income.

ARTICLE X **CLAIMS PROCEDURES**

As a Participant in the Plan You will automatically be provided with an electronic payment card, which is linked to Your Account. Rather than paying a provider upfront and waiting to be reimbursed, You, Your Spouse and Dependents can use the payment card to electronically access funds to pay providers that accept VISA® or MasterCard®. You should treat it like cash and secure it carefully. The Cardholder Agreement contains terms between You and the card issuer. In addition, You, Your Spouse and Dependents can submit claims online, through fax or mail.

10.1 Submission of Claims

- (a) You should use the payment card to pay expenses at any qualified provider who accepts VISA® or MasterCard®. Each time the card is used, funds are automatically deducted from Your Account. If it cannot be clearly determined that the funds were used for

eligible expenses per IRS guidelines, You will be notified to submit any applicable receipts. It is important that You retain receipts for all payment card purposes.

- (b) If You cannot or choose not to use the payment card for an eligible expense, You can submit a claim to request reimbursement. You will enter claim information online through a secure web site, print out a claim submission cover sheet to fax in or email with required documentation. Alternatively, You can enter claim information on a paper claim form that can be faxed or mailed with the required documentation.
- (c) You can continue to submit claims for expenses Incurred during the Plan Year for [90] days after the end of the Plan Year. Requests for reimbursement received after that time will not be honored.

10.2 Substantiation of Expenses

- (a) When submitting a claim, You must attach a copy of the original itemized bill or receipt for the expense. The bill, receipt or other statements from an independent third party should clearly show the person Incurring the expenses, the nature of the expenses, the date the expense was Incurred, the amount of the requested reimbursement and other details that may be requested by the Plan Administrator.
- (b) If the Account was accessed by an electronic payment card, You will be required to comply with the same level of substantiation. In the event that additional documentation is needed, a notification and request will be sent to You. You will have 45 days to submit the required documentation. If the additional documentation is not received in the time frame specified or if it is received but it is determined by the Plan Administrator that the charge was not for an eligible expense, then You will be required to refund the reimbursed amount to the Account. Tax consequences may apply and the electronic payment card's usage will be suspended. If Your card is suspended, You will need to submit online or paper claims for future requests for reimbursement, and the reimbursements for paper claim requests may be applied to the outstanding payment card transaction.

10.3 Initial Claims Decision

- (a) While many claims will be processed sooner than 30 days, the law provides that a 30-day period to process a claim is reasonable. The law also provides that if there are special circumstances, the 30-day period can be extended to 45 days. If an extension of time from 30 days is needed for processing, written notice of the extension will be furnished before the end of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a decision on the claim is expected to be given. If the extension is necessary to request additional information, the extension notice will describe the required information, and You will be given at least 45 days to submit the information. The Claims Administrator then will make its determination within 15 days from the date the Plan receives the additional information, or, if earlier, the deadline to submit the additional information. All actions of the Claim Administrator are on behalf of the Employer.

- (b) If a claim under the Health FSA or DCAP is denied in whole or in part, the Claims Administrator will notify the claimant of the decision by written notice, in a manner calculated to be understood by the claimant. The notice will set forth:
 - (1) The specific reasons for the denial of the claim;
 - (2) A reference to specific provisions of the Plan on which the denial is based;
 - (3) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
 - (4) For the Health FSA only:
 - (A) An explanation of the procedure for review of the denied or partially denied claim, including the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
 - (B) A disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and
 - (C) If the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

10.4 Appealing a Denied Claim.

If a claim is denied in whole or in part, You or Your authorized representative has the right to request the Plan Administrator to review the claim. This request must be submitted in writing. You may appeal the denial by using the following procedure:

- (a) Within 180 days of receipt of a notice of denial on the claim, You or Your authorized representative must send a written request for a review of the claim. The request should be sent to the Claims Administrator, which will forward the request for review to the Plan Administrator. You must submit issues and comments in writing. These actions must be taken at Your own expense. If You fail to file a request for review within 180 days of the denial notification, the claim is deemed abandoned and You are precluded from reasserting it.
- (b) Within 60 days after the request for review is received, the Plan Administrator will make a decision. The decision on review will be in writing and will include:
 - (1) The specific reason or reasons for the denial of the claim;

- (2) A reference to specific Plan provisions on which the adverse determination was made;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- (4) For the Health FSA only:
 - (A) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under ERISA section 502(a);
 - (B) A disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and
 - (C) If the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding.

ARTICLE XI

PLAN ADMINISTRATION

11.1 Amendment or Termination.

Although the Employer intends to continue this Plan indefinitely, the Employer expressly and specifically reserves the sole and exclusive right at any time to amend or terminate the Plan. Any amendment or termination will be evidenced by a written instrument duly executed by an officer of the Employer.

11.2 Plan Expenses

- (a) All reasonable expenses incurred in administering the Plan will be paid by the Employer for Participants in the Plan. If any expenses are charged to You (for example, the charge associated with requesting a replacement or second electronic payment card), notification will be provided.
- (b) If COBRA continuation is elected, the Employer will no longer pay the expenses incurred in administering the Plan, and the Account will be reduced for all reasonable administrative expenses.
- (c) All forfeitures will be used by the Employer to offset any losses it has incurred for benefit payments under the Plan and/or to reduce costs of administering the Plan. After this, forfeitures may be used in any manner authorized by relevant law.

11.3 Named Fiduciaries.

The Named Fiduciary of this Plan is the Employer, which may designate other Named Fiduciaries of the Plan.

11.4 Fiduciary Duties.

Each Fiduciary must discharge its duties with respect to the Plan:

- (a) Solely in the interest of Participants and for the exclusive purpose of providing benefits to them and defraying reasonable expenses of administering the Plan;
- (b) With the care, skill, prudence, and diligence under the circumstances that a prudent person acting in a like capacity and familiar with like matters would use in the conduct of an enterprise of like character and with like aims; and
- (c) In accordance with the documents and instruments governing the Plan insofar as the documents and instruments are consistent with the provisions of ERISA.

11.5 Fiduciary Liability.

- (a) For Fiduciary's Own Actions. No Fiduciary is liable for its own act, or failure to act, unless the Fiduciary causes actual loss to the Plan or to a Participant by failing properly to discharge a fiduciary duty or responsibility expressly imposed upon the Fiduciary by the Plan or by law.
- (b) For Actions of Other Fiduciaries. No Fiduciary is liable for the act, or failure to act, of another Fiduciary unless the first Fiduciary commits one or more of the following breaches of his fiduciary responsibilities:
 - (1) If he participates knowingly in, or knowingly undertakes to conceal, an act or omission of another Fiduciary, knowing the act or omission is a breach;
 - (2) If, by his failure to observe applicable standards in the administration of his specific responsibilities which give rise to his status as a Fiduciary, he enables the other Fiduciary to commit a breach; or
 - (3) If he has actual knowledge of a breach by the other Fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

11.6 Indemnity for Liability.

The Employer indemnifies each Employee, officer, and director of the Employer, and all persons formerly serving in this capacity, acting on behalf of the Plan, against any and all liabilities or expenses, including all legal fees relating thereto, arising in connection with the exercise of their duties and responsibilities to the Plan, provided however that the Employer does not indemnify

any person for liabilities or expenses covered by insurance nor due to that person's own gross negligence or willful misconduct.

11.7 Inability to Locate Payee

If the Plan Administrator is unable to make a payment to You, Your Spouse and Dependents because the Plan Administrator cannot ascertain Your identity or the identity of Your Spouse or Dependents or the Plan Administrator cannot ascertain Your whereabouts or the whereabouts of Your Spouse or Dependents after reasonable efforts have been made, then such payments will be forfeited following a reasonable time after the date any such payment first becomes due.

11.8 Indemnification of Employer

If You receive one or more payments or reimbursements under this Plan on a tax-free basis that do not qualify for tax-free treatment under the Code, then You will indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from the payments or reimbursements.

11.9 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and all regulations issued thereunder. In addition, it is intended that the Health FSA meet all applicable requirements of ERISA and all regulations issued thereunder. In the event of any conflict between any provisions of the Code and/or ERISA, the provisions of the Code and ERISA will control, and any conflicting provision of this Plan will be superseded to the extent of the conflict.

11.10 Applicable Laws

The provisions of the Plan will be construed, administered and enforced according to applicable Federal law and the laws of the State of the principal place of business of the Employer to the extent not preempted.

11.11 Gender

Any masculine pronouns used in the document include the feminine as well.

11.12 Effect of Mistake

Clerical errors or omissions in information provided to You do not deprive You of Your right to receive a benefit, and do not affect the amount of Your benefit. Conversely, clerical errors or omissions do not cause You to have the right to receive a benefit to which You are not entitled and if You receive an overpayment by mistake, You must repay the overpayment, if requested to do so. The Employer, through the Claims Administrator, reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any overpayment, or making catch-up payments to You for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's

right thereafter to enforce such provision, nor does such failure affect its right to enforce any other Plan provision.

11.13 Headings

The headings of the various sections are inserted for the convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning of any provision.

ARTICLE XII **STATEMENT OF ERISA RIGHTS**

As a Participant in the Health FSA Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office or at the Human Resource office, all Plan documents governing the Plan and a copy of the latest annual report (5500 series) filed by the Plan with the U.S. Department of Labor (if any). You may also request and examine the Plan's qualified medical child support order ("QMCSO") procedures at no charge.
- Obtain, upon written request to the Plan Administrator, copies of all Plan documents governing the Plan and a copy of the latest annual report (5500 series) filed by the Plan with the U.S. Department of Labor (if any). The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report.
- Continue healthcare coverage for You, Your Spouse or Dependents if there is a loss of coverage under the Plan as the result of a Qualifying Event. You, Your Spouse or Dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for You, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and beneficiaries. No one, including the Employer or any other person, may fire an Employee or otherwise discriminate against him in any way to prevent him from obtaining Plan benefits or exercising his rights under ERISA.

If the claim for a benefit is denied or ignored, in whole or in part, the Employee has 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 the Employee can take to enforce these rights. For instance, if an Employee requests materials from the Plan and does not receive them within 30 days, he may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the Employee up to \$110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If You have a claim for benefits that 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 or a medical child support order, You may file suit in 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 may file suit in federal court. The court will decide who should pay court cost 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, it could do so if it finds Your claim to be frivolous.

If You have any questions about the Plan, You should contact the Plan 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 Plan 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.

ARTICLE XIII **HIPAA PRIVACY AND SECURITY**

13.1 Permitted Uses and Disclosures of PHI by the Employer.

The Plan only may disclose protected health information to the Employer, to enable the Employer to carry out Plan administration functions or as otherwise permitted by the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Rule"). Only persons involved with Plan administration functions may have access to any information disclosed under this Article. If the persons to whom information is disclosed violate this section, or applicable law, the Plan shall cease disclosing such information.

13.2 Definitions.

Unless otherwise indicated, any definitions under this Article shall have the meaning given them under the HIPAA Privacy Rule.

13.3 Certification.

The Plan only will disclose information to the Employer under this Article upon a certification by the Employer of the following:

- (a) Further Disclosure. The Employer agrees not to use or further disclose the information obtained under this Article other than as permitted or required by the Plan document, or as required by law.
- (b) Agents. The Employer will require that any agents, including any subcontractors, to whom it provides protected health information received under this Article agree to the same restrictions and conditions that apply to the Employer with respect to such information.
- (c) Employment Actions. The Employer agrees not to use or disclose any information received under this Article for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Employer.
- (d) Duty to Report. The Employer will report to the Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for under this Article of which it becomes aware.
- (e) Access. The Employer will make available any information it holds under this Article in order for the Plan to comply with the access requirements under the HIPAA Privacy Rule.
- (f) Amendment. The Employer will make available any information it holds under this Article in order for the Plan to comply with the amendment requirements under the HIPAA Privacy Rule, and will incorporate any amendments to Protected Health Information it holds, as required under the HIPAA Privacy Rule.
- (g) Accounting. The Employer agrees to document and provide a description of any disclosures of protected health information, and information related to such disclosures, as would be required for the Plan to respond to a request by an individual for an accounting of disclosures of protected health information in accordance with the HIPAA Privacy Rule.
- (h) Internal Books. The Employer agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the HIPAA Privacy Rule.
- (i) Return of Information. The Employer will, if feasible, return or destroy all protected health information received from the Plan that the Employer maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further uses or disclosures of the information to those purpose that make the return or destruction of the information infeasible.
- (j) Adequate Separation. The Employer will establish adequate separation between the Employer and the Plan, as required under the HIPAA Privacy Rule, and the Employer will limit access to protected health information to those employees or classes of employees entitled to use or disclose such information and will require that these employees only may use or disclose such information for the Plan administration functions.
- (k) Noncompliance. The Employer will resolve issues of noncompliance with the terms of this Article by persons entitled to use or disclose protected health information in a timely manner.

13.4 HIPAA Security Standards

- (a) Safeguards. The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, as defined in the HIPAA Security Standards, 45 CFR Parts 160, 162 and 164, that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.
- (b) Agents. The Employer will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.
- (c) Security Incidents. The Employer will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.
- (d) Adequate Separation. The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and the Employer, in support of the requirements described in this Article.

ARTICLE XIV
ENDORSEMENT

In witness whereof, and as conclusive evidence of the adoption of the foregoing document comprising the Cafeteria Plan, the Employer has caused this Plan to be executed in its name and on its behalf.

Mount St. Mary's University

Signature

Printed Name

Title

Date

APPENDIX A
CONTINUATION COVERAGE RIGHTS UNDER COBRA

The below information describes Your right to COBRA continuation coverage under the Health FSA, which is a temporary extension of coverage under the Plan. **This information generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under federal law, You should contact the Plan Administrator.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the Spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your Spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-Employee dies;
- the parent-Employee's hours of employment are reduced;

- the parent-Employee's employment ends for any reason other than his or her gross misconduct;
- the parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the plan as a “Dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Employer.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for the Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium.

If you are interested in this alternative, contact Mount St. Mary's University for more information. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (“EBSA”) in Your area or visit the EBSA website at <http://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.