University of San Francisco
San Francisco Health Care Security Ordinance
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Summary Plan Description

Original Effective Date of Plan: December 31, 2009
Most recently amended and restated effective: January 1, 2016

INTRODUCTION

We are pleased to announce that we have established a Health Reimbursement Arrangement (HRA) for you and other eligible employees. This Plan is intended to comply with the requirements of the San Francisco Health Care Security Ordinance (HCSO), as amended. Under this program, you will be able to receive reimbursement for the cost of eligible expenses without taxation to you individually. The purpose of this Summary Plan Description (hereafter referred to as the “SPD”) is to describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the HRA, such as the rules of the HRA and the laws that protect your rights.

One of the most important features of our HRA is that there is no cost for you to participate. All administration and benefits costs are paid entirely by the employer.

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 goal with the HRA is to provide you with a meaningful health benefit with the maximum flexibility.

Read this SPD carefully so that you understand the provisions of the HRA and the benefits you can receive. We want you to be fully informed of your rights and obligations. You should direct any questions you have to Human Resources or BASIC pacific, our contract administrator. In addition to this SPD, there is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this SPD and the Plan Document, the Plan Document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this HRA, if there is a conflict between an insurance contract and either the Plan Document or this SPD, the insurance contract will control.
SECTION 1: GENERAL INFORMATION ABOUT OUR PLAN

1-1. This Section contains general information about the Plan that you need to know:

- University of San Francisco SFHCSO Health Reimbursement Arrangement (the Plan) is the name of the Plan.

- The Plan Sponsor and Plan Administrator's name, address, and Federal Tax Identification Number is:
  
  University of San Francisco
  Office of Human Resources
  2130 Fulton Street, LMM 339
  San Francisco, California 94117

- The provisions of the Plan became effective on December 31, 2009, which is called the Effective Date of the Plan.

- If this is an amendment of an existing Plan, the amended Plan becomes effective on January 1, 2016.

- The Plan records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins January 1 and ends December 31 each year.

- The Plan is a welfare benefit plan which has been designated by the Plan Sponsor. The ERISA Plan Number (if the applicable) of the Plan is 501.

- The Plan shall be governed under the laws of the State of California.

- The Plan is intended to comply with the requirements of the San Francisco Health Care Spending Ordinance, as amended or modified.

- The ERISA Plan Administrator (the Employer) has elected to contract with an outside party to assist with the day-to-day operation of the Plan. This outside party is referred to as the Contract Administrator, or Third-Party Administrator (TPA). Listed below is the name, address and business telephone of the TPA:
  
  BASIC pacific (Formerly CBA)
  P.O. Box 2170
  Rocklin, CA 95677
  (916) 303-7090

  The Contract Administrator keeps the records for the Plan and is responsible for the day-to-day operation of the Plan. The contract administrator can also answer most, if not all, questions you may have about our Plan. You may contact the Contract Administrator for any further information about the Plan.

- The name & address of the Plan's agent for service of legal process is:
  
  University of San Francisco
  Office of Human Resources
  2130 Fulton Street, LMM 339
  San Francisco, CA 94117

- All Employees of the Employer are eligible to participate in this Plan except:
  
  ☒ Employees who work for employers that are not required to comply with the HCSO.
Part-time Employees who are regularly scheduled to work less than 8 hours per week in the city/county of San Francisco (averaged over the course of each calendar quarter).

Employees who do not work in the City or County of San Francisco.

Employees who's employer contribute more than the required quarterly expenditure on other health benefits that fulfill the employer's obligation under the HCSO.

Employees that earn more than the applicable salary exemption amount ($92,990.00 for the year or $44.71 per hour in 2016). The salary exemption amount is indexed for inflation each calendar year

Employees who are covered by Medicare or TRICARE CHAMPUS

Employees who are employed by a non-profit corporation for up to one year as trainees in a bona fide training program consistent with Federal law

Employees who receive health care benefits pursuant to the San Francisco Health Care Accountability Ordinance are not covered by the Ordinance.

- Covered Employees may be reimbursed for eligible expenses “incurred” (rendered or performed) for themselves and their qualified dependents.

- If you are a newly hired employee and you are otherwise eligible, your participation in the Plan will commence on the first day of the month following 90 days of employment with your employer.

- You may not be reimbursed for any expenses “incurred” (meaning the date of service, not the date you pay) before you become a participant in the Plan.

- The Plan will reimburse you for your cost of eligible medical care as defined under Internal Revenue Code Section 213 and as further described below:

**For contributions earned AFTER December 31, 2013 (meaning January 2014 and after), The SFHCSO HRA will reimburse you for charges that you incur (meaning paid by you) for:**

- Dental and vision related expenses. Eligible expenses include, but are not limited to your cost for dental/eye exams, teeth cleaning, fillings, bridges, implants, orthodontia, TMJ treatment, prescription eyewear, prescription contacts and laser eye surgery;

- Expenses for long-term care, nursing home, home health or community based care;

- Your cost for a medical indemnity insurance policy (meaning a plan that pays you a fixed dollar amount for a specific medical condition or injury, such as a plan that pays you $500 if you break your arm);

- Your cost for an insurance policy that covers a specific disease or illness (such as a plan that covers cancer treatments exclusively);

- Your cost for an individual insurance policy that covers dental and/or vision expenses exclusively; and,

- Your cost for transportation to obtain a covered expense, including an allowance for mileage if you drive. In order to be eligible for transportation reimbursement, the transportation expense must be incurred exclusively to obtain a covered expense. For example, you may not seek reimbursement of your cost to commute to work simply because you also received dental care while at work. You must also be able to tie the transportation to the covered expense (for mileage reimbursement, you must report the miles driven). Finally, the cost for transportation must be necessary and reasonable. For example, you may not be reimbursed for the cost of driving 200 miles for a vision exam unless you can demonstrate that there was no qualified provider closer to your home.
• You may not be reimbursed for any expense that is paid for by any other source. For example, if you incur a covered dental expense for $200 and you have other dental coverage that pays 50% ($100) toward the charge, you may only seek reimbursement for the remaining $100 from the HCSO HRA.

• To be eligible, the expense must be medically necessary (meaning the expense cannot be solely for cosmetic purposes) and must be incurred while you are actively covered under the HCSO HRA.

• You may not be reimbursed for membership fees, access fees or other charges that are not directly related to actual services or qualified premiums for the plans listed above.

• The maximum total number of work hours that your employer is subject to under the HCSO is 172 per month, meaning you may only earn an employer expenditure up to a maximum of 172 hours of creditable work per month.

• For 2014 Plan Year contributions ONLY: The maximum number of hours that may be allocated to this Plan for purposes of fulfilling your employer’s spending requirement is 260 hours per calendar quarter (20 hours per week equivalent). If you earn more creditable hours in a calendar quarter, your employer will allocate the excess to another plan. Contact your employer if you are unaware of how excess allocations are being allocated.

• For 2015 Plan Year contributions ONLY: 40% of your employer’s total health care spending requirement earned in 2015 will be directed to the HCSO HRA. Contact your employer for information about the remaining 60%.

• For 2016 Plan Year contributions ONLY: 20% of your employer’s total health care spending requirement earned in 2016 will be directed to the HCSO HRA. Contact your employer for information about the remaining 80%.

• Your current account balance is equal to the total of your employer’s maximum permitted quarterly contribution each calendar quarter, minus your monthly administration fee, the amount paid to you for previous claims and any amounts that have been forfeited.

• If you earn an ESR in a calendar quarter, the amount contributed to your account will be available to you on or about the end of the month following each quarter. For example, an ESR earned in the first quarter of 2016 will be deposited to your account on or about April 30, 2016.

• You will be sent a notification (called a Contribution Summary”) after each Employer Contribution is made to your account.

• Qualified services and/or expenses must be rendered (performed) prior to requesting reimbursement under the Plan.

• While you must have “incurred” an expense before requesting reimbursement, you are not required to prove that you have paid for a medical service prior to requesting reimbursement. This special rule only applies to medical services that you receive. To be reimbursed for premium expenses, you must demonstrate that you have paid the expense before you may request reimbursement.

• Your participation in the Plan will terminate on the earliest of the following events:
  o The 90 days following the date on which your employment terminates; (1)
  o The date on which you no longer qualify to participate in the Plan; or, (1)
  o The date on which the Employer terminates the Plan.
  (1) If you lose your coverage as a result of this event, you may be eligible to extend your benefit under COBRA.
After midnight on December 31st of each year, the unclaimed balance in your account will be rolled-over and applied toward your available balance in the next plan year after deducting contributions that are more than 24 months old. For example, let’s say you have $1,000 in your account on December 31st, 2014. Let’s further say your employer contributes $1,000 in 2015 and $1,000 again in 2016. If you made no claims against your account during the entire period, your account balance would be $3,000 on December 31, 2016. However, only $2,000 would roll-over and be available for reimbursement in 2017. Why? Because the $1,000 in your account on December 31, 2014 would be more than 24 months old and will no longer be available.

If you are an active participant as of December 31st each year, you will have until March 31st of the following year to submit claims for services rendered during the previous year. This is referred to as the claims “run-out period”. Claims received after the claim run-out period ends will not be eligible for reimbursement under the Plan. Remember also that immediately following December 31st each year, funds not used for two years will be subtracted from your available account balance. This could impact the amount you can be reimbursed during the claims run-out period.

If you terminate employment or otherwise lose your eligibility to participate in the Plan, your participation will cease 90 days after the date you lost eligibility. For example, if you terminate employment on March 1, 2016, you will remain an active participant until May 29, 2016. Using this example, you could continue to be reimbursed for qualified expenses incurred until May 29, 2016 even though you terminated employment on March 1, 2016.

If you terminate employment or otherwise lose your eligibility to participate in the Plan, you will have an additional 90 days to submit claims to the administrator. Expanding on the example immediately above, if you terminate employment on March 1, 2016, you will have until August 28, 2016 to submit claims for qualified expenses incurred no later May 29, 2016. The term “submit” in this instance means received by the administrator, so you cannot wait to mail your claim on the 90th day.

If you lose your eligibility to participate due to a termination of employment, you will be sent a special “Separation Notice” shortly after your termination date. The Separation Notice will include the final contribution to your account, your current account balance and your deadline to submit claims for reimbursement.

A monthly administration charge will be deducted from your account balance. The amount of the charge is $4.35 per month. The amount of the charge may change in future plan years.

If you elect to continue the Plan under COBRA, you will be required to pay the full COBRA premium for the Plan.

If the Employer sponsors a Health Flexible Spending Account (Health FSA) in addition to this Plan (and you are able and elect to participate), eligible expenses must be paid by this Plan BEFORE the expense may be paid under the Health FSA.

Reimbursements are issued each Wednesday & Friday (except holidays). The claims cut-off is 8:30 am Pacific on the previous business day.

SECTION 2: QUESTIONS & ANSWERS

2-1. What is the purpose of the Plan?
The purpose of the HCSO HRA is to provide a source of funds that are available to reimburse you for eligible medical, dental and vision related expenses incurred while you are a participant in the Plan.

2-2. **When did the Plan take effect?**

Refer to SECTION 1 of this document for a description of the effective date for our Plan.

2-3. **Who will make all of the contributions to the Plan?**

Your employer will make all of the contributions necessary to fund the benefits under the Plan while you remain an active participant. If you lose your eligibility to participate and elect to extend the benefit under COBRA, you will be responsible to pay for the cost of the benefit.

2-4. **How do I become a Participant?**

If you are otherwise eligible to participate, you will commence participation in the Plan as of the first day of the month following 90 days of employment with your employer. Once you have met the eligibility waiting period, your employer will help you to enroll in the Plan. Your enrollment materials provide detailed information about the requirements to enroll in the Plan. Contact your employer or BASIC pacific if you have questions about your enrollment requirements.

2-5. **How do I receive my benefits under the Plan?**

When you incur an eligible expense, you must submit a claim for reimbursement to the administrator within the time frames set forth in this Plan. If the administrator determines that your claim is valid, you will be reimbursed in accordance with the reimbursement cycle. Refer to your enrollment material for a description of your reimbursement cycle. You may submit a claim for any eligible expense “incurred” the date the service is rendered) while you are a Covered Employee under the Plan. Remember, though, you can't be reimbursed for expenses that exceed your available account balance on the date your claim is processed. If your claim arises while you are eligible for COBRA continuation coverage, all required premiums for the coverage also must have been received by the administrator prior to reimbursement of an otherwise eligible expense.

To be reimbursed for an eligible expense, you must submit a complete & legible claim form along with third-party documentation to support your claim. The materials provided by your employer include a claims form. “Third-party” documentation means it is provided to you by your service provider (e.g. doctor, dentist, health clinic, etc.) or your insurance carrier. The documentation provided by your insurance carrier is usually referred to an Explanation of Benefits (EOB). Documentation for each expense for which you are seeking reimbursement must include: (1) the full date of service (not the date of payment); (2) the name of the service provider; (3) the patient’s name; (4) a brief, but clear description of the services provided; and, (5) the cost, or your portion of the cost for the service.

2-6. **Is there a charge to reissue a reimbursement?**

Yes. If BASIC pacific has to reissue a reimbursement for any reason, you will be charged a fee of $25. This fee applies if BASIC pacific has to replace a lost, stolen or undelivered check. In addition, this fee applies if BASIC pacific has to reissue a direct deposit that was not honored due to your error (such as providing BASIC pacific with inaccurate bank account information, whether BASIC pacific issues a new direct deposit or issues a check in lieu of a direct deposit. The fee will be deducted from your account balance. For example, if you have a remaining maximum benefit of $300 and you are charged this fee, your new remaining balance will be $275.

2-7. **When must expenses be incurred?**

You may not be reimbursed for any expenses incurred before the Plan became effective, or if later, prior to the time you became a Covered Employee under the Plan. For purposes of the Plan, you are considered to have “incurred” an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have paid for a service.
2-8. What happens if my claim for benefits is denied?
If your claim is denied in whole or in part you will be notified in writing by the administrator within 30 days of the date you submitted your claim. If you do not receive notification of the denial of a claim within the 30 day period, then if the claim is not otherwise paid, it will be deemed denied. The notification will explain the reason(s) why your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review (i.e. an appeal) of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. Refer to SECTION 3 of this document for more information regarding your rights to appeal a denied claim.

2-9. Will my coverage end if I go on a family or medical leave under FMLA?
If your Employer is required to comply with FMLA, and subject to certain conditions, the Family and Medical Leave Act (“FMLA”) entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave. If you fail to return to work after your FMLA Leave ends or you terminate your employment during your FMLA Leave, you will be treated as though you terminated employment on that date.

2-10. Does my coverage continue while I am absent on duty in the uniformed services?
The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth under COBRA. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The “uniformed services” are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

2-11. How long will the Plan remain in effect?
Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

This Plan may be amended or terminated by a written resolution adopted by a majority of the Employer’s Board of Directors, or the Owner(s) of the Employer if the Employer is not a corporation. The Plan will also automatically terminate if the Company (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company’s successor in interest agrees to assume the liabilities under this Plan as to the Participants. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the plan year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

2-12. Is this Plan an excepted benefit under the Health Care Reform (HCR) laws?
Yes. This plan is an excepted benefit under HCR.
SECTION 3: CLAIMS

3-1. Deadlines
If you are an active participant, to ensure you receive the maximum benefit possible, you must submit claims for reimbursement no later than the last day of each plan year (December 31st). This is because unclaimed contributions at least 24 months old (if any) will be forfeited immediately after the end of each calendar year. This could reduce the total benefit amount available to you. However, you will still have until 90 days after the end of each year (March 31st) to submit claims for services rendered by the last day of the Plan year.

If you terminate employment during the plan year, you will remain an active participant for an additional 90 days. You will then have an additional 90 day period to submit claims for reimbursement that were incurred by the 90th day following the date you terminated. Claim requests should be directed to the contract administrator of the Plan (BASIC pacific).

3-2. Documentation of Claims
Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

3-3. Method and Timing of Payment
To the extent that the Plan Administrator approves a claim, the administrator may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per month. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

3-4. Where to Submit Claims
All claims must be submitted to the contract administrator, BASIC pacific, at P.O. Box 2170, Rocklin, CA 95677. The telephone number is Phone - 800-574-5448; Fax - 800-584-4591. BASIC pacific is a contract administrator that is responsible for the day-to-day administration of the Plan and is not a Plan Fiduciary or the Plan Administrator of the Plan. The Employer is the Plan Administrator of the Plan.

3-5. Refunds/Indemnification
You must immediately repay any excess payments/reimbursements. You must reimburse the Plan Administrator for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Employer may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

3-6. Beneficiary
If you die, your beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose provided that such beneficiary is your spouse or one or more of your dependents. If no beneficiary is specified, the Plan Administrator may pay any amount due to your spouse or, if there is no spouse, to your dependents in equal shares.

3-7. Claim Procedures for Health Benefits
Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, if applicable, and (5): (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan (or a designated representative thereof) who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (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, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.
SECTION 4: ADDITIONAL PLAN INFORMATION

4-1. Plan Accounting
The administrator shall periodically furnish you with a statement of your account for you to use in determining how much additional benefits remain in your account prior to the end of the plan year. You may also make a written request to receive a statement of your account from the plan administrator at any time.

4-2. Continuation of Coverage.
Federal law (known as "COBRA") requires that some employers sponsoring group health plans offer certain employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. COBRA continuation coverage is paid for by the eligible employee or the employee's eligible family members. Generally, an Employer is subject to these federal COBRA requirements if it employs 20 or more employees during the majority of business days in the previous calendar year. For example, if your employer had 25 employees during the entire previous calendar year, your Employer would be subject to federal COBRA in the current year.

If you are an employee covered under the Plan, you may have the right to choose this continuation coverage if you lose your Plan coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

4-3. Your rights under HIPAA
You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. This provision does not apply to the Health FSA, which is an "excepted benefit" under HIPAA.

4-4. Your HIPAA Privacy Rights.
Under another provision of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from your employer (or medical insurers) that outlines its health privacy policies. Note: For most employers, HIPAA Privacy provisions are effective as of April 14, 2004.

4-5. Claims Process
If you are an active participant, you must submit claims for reimbursement no later than the last day of each plan year (December 31st). If you terminate employment during the plan year, you will have an additional 90 day period during which you may continue to incur expenses and a further 90 day period to submit claims for reimbursement. Claim requests should be directed to the contract administrator of the Plan (BASIC pacific). If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) The reasons for the denial;
b) Reference to the specific provisions of the Plan on which the denial was based;
c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
d) A description of the Plan’s review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary shall have 180 days following the receipt of any notification of Claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the Claim, without deference to the initial denial and after taking into account all comments, information, documents, records and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 30 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

4-6. Non-Discrimination Requirements
To the extent that the Plan is treated as a self-insured medical expense Plan under Internal Revenue Code Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Internal Revenue Code Section 105(h).

4-7. Highly Compensated Employees
Under the Internal Revenue Code, if you are deemed to be a “highly compensated employee”, 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. Your own circumstances will dictate whether contribution limitations on “highly compensated employees” will apply. You will be notified of these limitations if you are affected.

4-8. No Employment Rights Conferred
Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

4-9. Privacy
The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

4-10. Qualified Medical Child Support Orders
In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

4-11. CONTINUATION RIGHTS – Military Service
If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.
4-12. Your Rights under ERISA

If your employer is required to comply with ERISA, as a Plan Participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act (“ERISA”). ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and 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 Benefit Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. The people who operate your Plan, called “Fiduciaries” of the Plan, have an affirmative duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan 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 Plan 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 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 your 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration, (800) 998-7542.
4-13. **Your Rights and Responsibilities under COBRA**

A federal law known as COBRA allows certain Participants and Dependents to continue coverage under the Plan even after certain qualifying events, such as termination of employment.

**COBRA Eligibility**

This section describes the continuation coverage rules provided under the Consolidated Omnibus Reconciliation Act of 1985, as amended (“COBRA”).

A Participant or Dependent who becomes a Qualified Beneficiary shall have the right to elect Continuation Coverage pursuant to the provisions of this section. Continuation Coverage shall be provided only where timely election of coverage and timely payment of any required contribution is made.

A Participant or Dependent shall become a Qualified Beneficiary at such time the individual loses coverage under the Plan because of a Qualifying Event.

A “Qualifying Event” shall mean a loss of coverage due to:

- The termination of a Participant’s employment with the Employer for reasons other than discharge for gross misconduct;
- A reduction of a Participant’s hours worked;
- The death of a Participant;
- Divorce or legal separation;
- A Participant becoming entitled to benefits under Medicare; or
- A Dependent child ceasing to qualify as a Dependent.

**Nature of COBRA Coverage**

A Qualified Beneficiary may continue the same coverage under the Plan as the coverage that is available to similarly situated Participants who have not experienced a Qualifying Event.

If coverage under the Plan is modified for Participants similarly situated to a Qualified Beneficiary, the modification in coverage shall also apply to the Qualified Beneficiary.

**Period of COBRA Continuation Coverage**

A Qualified Beneficiary may elect to continue coverage from the date of the Qualifying Event until the earliest of the following:

- The end of a period of:
  - 18 months, in a case where the Qualifying Event was termination of employment or reduction in hours;
  - 29 months, in a case where the Qualified Beneficiary has been determined under the Social Security Act to have been totally and permanently disabled any time during the first 60 days of COBRA continuation coverage; or
  - 36 months for any other Qualifying Events.

The date on which the Employer ceases to provide any group health plan to any Employees.

The date on which coverage ceases under the Plan because the Qualified Beneficiary failed to make timely payment of any required contribution.

After the date of election, the date on which the Qualified Beneficiary first becomes either:
Covered, as a participant or otherwise, under any other group health plan, unless the other group health plan contains a pre-existing condition limitation which restricts benefits, or

Entitled to benefits under Medicare (except in the case of entitlement to Medicare due to end stage renal disease).

In the case of a Dependent of a Participant, the continuation period may be extended to a maximum of 36 months if another Qualifying Event occurs within the 18 month period described in (a) above.

Under no circumstances shall Coverage Continuation be provided for more than 36 months after the date of the original Qualifying Event.

**COBRA Notices**

The Participant must notify the Plan Administrator within 60 days of any one of the following Qualifying Events:

- Divorce or legal separation.
- A Dependent child ceasing to qualify as a "Dependent".
- A determination of total and permanent disability by the Social Security Administration.

The Plan Administrator shall notify the Employer within 14 days of receipt of the Participant's notice. The Employer shall notify the Plan Administrator within 30 days of any other Qualifying Event.

The Plan Administrator shall notify the Qualified Beneficiary regarding his coverage continuation option within 14 days of the date the Plan Administrator receives notice of the Qualifying Event. The notice to the Qualified Beneficiary shall be in a form and shall contain the information required by COBRA.

- Notification to the Participant is deemed notification to all other Qualified Beneficiaries residing with the Participant. Notification to the parent is deemed notification to all minor Qualified Beneficiaries residing with the parent.

**COBRA Election Period**

The period during which the Qualified Beneficiary may elect Coverage Continuation is the 60 day period immediately following the later to occur of the date coverage under the Plan terminates or the date of the election notice. A parent with whom a minor Qualified Beneficiary resides shall be the person authorized to elect coverage on behalf of the minor.