

DRAKE UNIVERSITY

**SECTION 125 PRE-TAX SALARY REDUCTION
DEPENDENT CARE REIMBURSEMENT PLAN**

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Drake University (the “Employer”) is pleased to sponsor an employee benefit program known as a Pre-tax Salary Reduction Dependent Care Reimbursement Plan (the “Plan”). The Employer provides you with the opportunity to use pre-tax dollars to pay for selected benefits by entering into a Salary Reduction arrangement by which you elect to pay for the benefits instead of receiving a corresponding amount in your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your Salary Reduction.

This Summary describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official Plan documents. If there is a conflict between the Plan documents and this booklet, the Plan documents will apply.

The Plan will be interpreted to comply with applicable provisions of the Internal Revenue Code.

PART I. GENERAL INFORMATION **ABOUT THE DEPENDENT CARE REIMBURSEMENT PLAN**

Q-1 What is the purpose of the Plan?

The purpose of the Plan is to allow Eligible Employees to use funds provided through Employee Salary Reduction, to choose the benefit offered through the Plan, and enable them to pay for eligible Dependent Care Expenses with pre-tax dollars.

Q-2 What is considered an eligible Dependent Care Expense?

“**Eligible Dependent Care Expenses**” means expenses that are considered to be employment-related expenses under Code § 21(b)(2), relating to expenses for household and dependent care services necessary for you to be gainfully employed or to attend school full-time, if paid to provide for Qualifying Dependent Care Services. If you are married, then the expenses must be incurred so that both you and your Spouse can work, unless your Spouse is a full-time Student or incapable of self-care.

Covered Dependent Care Expenses include payments made for dependent child and adult dependent care services provided either in your home or outside your home, as long as they are incurred in order for you and your Spouse to work or to go to school full-time. All expenses must be for “care”. Some examples of the kinds of expenses that may qualify are:

- After-school day care expenses.
- Family or adult daycare for an elderly parent or Spouse.

- Nursery school expenses.
- Tuition for eligible Dependents that have not yet reached kindergarten.
- Transportation expenses charged by the provider to transport child to and from school
- Summer day camp expenses. However, the cost of overnight camps are not eligible for reimbursement.

Q-3 What Dependent Care Expenses are excluded from coverage under this Plan?

Some examples of the Dependent Care Expenses that do not qualify for reimbursement include:

- Educational expenses for kindergarten, 1st grade, and above.
- Expenses for food and clothing.
- The cost of overnight camps, even if the overnight charges can be separated out.
- The cost of expenses for dependent care, while you are off work for an extended period of time due to illness or maternity leave.

Q-4 Whose expenses qualify for Dependent Care under this Plan?

The Dependent Care Expenses of the following persons qualify under this Plan:

- Your Dependent under the age of 13.
- Your Dependent or Spouse who is physically or mentally incapable of self-care and who lives with you for more than half the year.

A person's status is determined on a year-by-year basis.

A Dependent is your qualifying Child or other qualifying Relative.

A qualifying Child is a person who is your natural or adopted child, step-child, foster child or sibling or a descendant of any such person and:

- who resides with you for more than half the year;
- who has not attained age 19 (or age 24 if a full-time student) by the end of the year or who is permanently and totally disabled; and
- who does not provide more than one-half of his own support.

A qualifying Relative is a person who is your natural or adopted child or that child's descendant; your sibling or step-sibling; parent or your parent's ancestor, your uncle or aunt; step-parent, son- or daughter-in-law; father- or mother-in-law; brother- or sister-in-law ; or a person who has your home as his or her principal place of abode and is a member of your household; and:

- who receives more than half of his or her support from you; and
- who is not your qualifying Child or the qualifying Child of any other taxpayer.

Your Spouse is the person of the opposite sex to whom you are legally married and who lives with you more than half the year.

Q-5 Who can provide dependent care?

Any person can provide dependent care subject to the following limitations:

- If the services are provided by a dependent care center that provides care for more than 6 persons, it must comply with all state and local laws that apply to such facilities.
- Services provided by your child under age 19 or by any person that you can claim as an exemption on your federal income taxes, or by a parent of the child are not eligible under this Plan.
- Services provided outside your home to a person age 13 or older are eligible only if the person normally spends at least 8 hours a day in your home.

Q-6 What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Pre-tax Dependent Care Reimbursement Plan by filling out any required enrollment form(s) for the Plan. This benefit option will be described to you in information materials distributed prior to each enrollment period and in this summary.

Q-7 What is the Debit Card?

The *mbi* Benefits Card (™) hereinafter called “the debit card,” is a debit card that can be used to pay your qualifying Dependent Care Expenses when they are incurred, up to the amount of the balance in your Dependent Care Account. It automatically filters companies by their merchant category codes, so that it can only be used at Dependent Care Centers. All Employees who elect to participate in the Plan are eligible to participate in this debit card program.

Q-8 Who can participate in the Plan?

Employees who are regularly scheduled to work at least 9 months of the Plan Year and 32 or more hours per week are eligible to participate in the Plan. New employees

become eligible to join the FSA plan the first of the month following the date of hire and receipt of a completed election form, or for any subsequent Plan Year, as described in Section 3.2.

“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W2 payroll, but does not include (a) any leased employee (including, but not limited to those individuals defined in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer’s W-2 payroll or are determined to be common-law employees of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency, whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

Those Employees who actually participate in the Plan are called “Participants”. An Employee will be a Participant for a given Plan Year until the earliest of the following events:

- the end of the Plan Year for which the election was made;
- the termination of the Plan;
- the date the Participant’s employment ceases; or
- the date the Participant revokes his or her election in accordance with Q-12.

Q-9 What tax advantages are available through the Plan?

You save both federal income tax and Social Security taxes by participating in the Plan. Following is an example of the tax savings you might experience by participating in the Plan.

Suppose your monthly gross pay is \$2,500 and your cost for out-of-pocket Dependent Care Expenses is \$140.00 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for dependent care from your after-tax pay, your take home pay is \$1,794.00. However, under the Plan, you will be considered to have received \$2,360.00 gross pay rather than \$2,500 for tax purposes with \$140.00 contributed for out-of-pocket Dependent Care Expenses. This means your take home pay will be \$1,825.00 with the Plan rather than \$1,794.00 without it. Thus, you save \$31.00 per month (\$372.00 per year) by participating in the Plan. The Table below illustrates this savings.

	<u>With Cafeteria Plan</u>	<u>Without Cafeteria Plan</u>
Gross Monthly Pay	\$2,500.00	\$2,500.00
Pre-Tax Dependent Care Expense Deduction	<u>-140.00</u>	<u>-0.00</u>
Taxable Income	2,360.00	2,500.00
Estimated Federal Tax (15%)	-354.00	-375.00
FICA Tax	-181.00	-191.00
After-tax Dependent Care Expense	<u>-0.00</u>	<u>-140.00</u>
Take Home Pay	<u>\$1,825.00</u>	<u>\$1,794.00</u>

Q-10 How do I become a Participant?

Employee Salary Reduction Contributions

You become a Participant by signing an individual Election Form on which you elect one or more of the benefits available under the Plan, as well as agree to a Salary Reduction to pay for those benefits so elected. You will be provided an Election Form when you first become eligible to participate. You must complete the form and turn it in to the Human Resources Department within thirty-one days of meeting the eligibility requirements. If you are eligible on the initial Effective Date of the Plan, you will be able to enter the Plan during the Initial Enrollment Period and shall become a Participant on the Effective Date. Otherwise, you will be able to enter the Plan on the first day of the first pay period next following your satisfaction of the eligibility requirements and the Employer’s receipt of your signed Election Form.

In future years, a new Election Form will be made available to you by the first day of the Open Enrollment Period, and you will be given the opportunity to confirm or change your choices made for the previous 12-month period for the upcoming 12 months beginning on the first day of the next Plan Year. This twelve-month period is called the “Plan Year”. If you do not complete, sign and file an Election Form as required, you will not be a Participant in the Plan for the next Plan Year, and may not enroll until the next Open Enrollment Period, unless you experience a qualifying Change in Status event.

Q-11 What is the Open Enrollment Period?

The Open Enrollment Period for a Plan Year will be the period prior to each Plan Year that the Employer declares to be the “Open Enrollment Period”.

Q-12 Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Pre-Tax Dependent Care Reimbursement Plan or vary the Salary Reduction amount you have selected during the Plan Year, although your election will terminate if you are no longer working for the Employer. Generally, you may change your election for Salary Reduction only during the Open Enrollment Period, and then, only for the upcoming Plan Year.

There are several important exceptions to this general rule:

1. **Qualifying Change in Status Events.** If one or more of the following qualifying Changes in Status occur, you may revoke your old election and make a new election, for the period of coverage remaining in the current Plan Year, provided that both the revocation and new election are on account of and correspond with the qualifying Change in Status (as described below).

Those occurrences, which qualify as a qualifying Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- *Legal Marital Status:* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
- *Number of Dependents:* Events that change a Participant's number of tax Dependents, including birth, death, adoption, and placement for adoption;
- *Change in Employment Status:* Any change in employment status of the Participant, the Participant's Spouse or the Participant's Dependents that affects the benefit eligibility under a cafeteria plan (including this Plan) or another cafeteria plan of the Employer of the Participant, the Spouse, or Dependents, such as: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, switching from salaried to hourly-paid or union to non-union or vice versa, incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time), or any other similar change which makes the individual become (or cease to be) eligible for a particular Employee benefit;
- *Dependent Eligibility Requirements:* An event that causes a Participant's Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as when the Dependent attains a specified age, gets married, or ceases to be a Student;
- *Certain Judgments and Orders:* If a judgment, decree or order from a divorce, separation, or annulment results in a custody change for a Participant's Dependent, the Participant may make a corresponding change in his or her election;
- *Change in Cost:* If a Participant's current dependent care provider changes the cost of the care being provided, the Participant can make a corresponding change to his or her dependent care election (*unless the dependent care provider is related to the Participant*);
- *Change in Dependent Care Provider:* If a Participant changes dependent care providers, he or she can make a corresponding election change to increase or decrease the amount contributed to his or her Dependent Care Reimbursement Account if the new provider charges a different rate; or

- *Change in the Amount of Dependent Care Required:* If the Participant's child begins attending school, thereby reducing the number of hours needed for care, the Participant may make a corresponding election change.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for the Plan within thirty-one days of the occurrence.

Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law, by requiring each participant to reduce their election by an equal percentage, until the defect is corrected.

2. **Change in Status-Other Requirements.** If you wish to change your election based on a qualifying Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status.

Q-13 Is there a limit to the dollar amount I may reduce or increase my election?

Yes, you may not increase your election to more than what the plan maximum will allow. Also, you may not reduce your election to less than the greater of your current year to date contributions, current year to date reimbursements, or the current available account balance.

Q-14 How does a mid-year election change effect my reimbursements?

You can only be reimbursed for qualifying expenses, from the election that was in place at the time the expense was incurred.

Q-15 What if I have expenses that were incurred prior to the effective date of my election change that have not been reimbursed?

If you have expenses incurred prior to the change in election and you have not yet submitted for reimbursement, you may be reimbursed up to the amount of your original annual election minus any previous year to date reimbursements.

Q-16 May I submit for expenses incurred prior to my election change against my new election balance?

No, any services incurred prior to the effective date of the election change are not eligible for reimbursement under the new election balance even if the previous balance as been depleted

Q-17 If I have a remaining balance under my prior annual election may I submit for expenses incurred after my election change against this balance?

Expenses incurred after the effective date of the election change, may not be reimbursed from any prior election balance.

Q-18 What if I do not have expenses to submit against my prior annual election?

If you did not incur any expenses or do not have additional expense to submit for reimbursement against you prior annual election, the balance of the prior annual election is forfeited.

Q-19 How many times during the plan year may I change my election?

Provided that you have a qualifying event that will allow for a mid-year election change, you may change your election up to twice in a plan year.

Q-20 Once I become a Participant, do I need to enroll in the debit card program?

No. When you become a Participant, you will automatically receive a debit card from the Plan, as well as a cardholder agreement describing the debit card's terms and conditions of use. In addition, each time you use the debit card, you will automatically be certifying:

- That you agree to the terms and conditions of the cardholder agreement;
- That you will only use the debit card to pay for eligible Dependent Care Expenses; and
- That you will retain the required documentation for any expense that is paid by the debit card.

Q-21 How are my Premium Payments made?

Salary Reduction Premiums Payments

When you become a Participant, contributions to your Dependent Care Reimbursement Account will be paid with that portion of gross income that you have elected to forego through pre-tax Salary Reductions.

Q-22 What if I terminate my employment during the Plan Year?

Employee Salary Reduction Contributions

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. Also, your debit card will be permanently inactivated at this time. However, if you have contributions remaining in your Dependent Care Reimbursement Account when your employment ends, you may still receive

reimbursements for Dependent Care Expenses incurred prior to your termination date by submitting a Request for Reimbursement form to the Plan as described in Q -26.

If you are a former Participant who is rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year. In such a case, you will be issued a new debit card and will receive a new cardholder agreement as soon as possible after the date you are rehired. If you are rehired more than 30 days following termination of your employment and you are otherwise eligible to participate in the Plan, then you must wait until the next Open Enrollment Period to participate unless you experience a qualifying Change of Status event, which would allow a mid-year election.

Q-23 Will I pay any administrative costs under the Plan?

The Employer is currently bearing the entire cost of administering the Plan.

Q-24 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-25 How do I use the Debit Card?

The debit card you will receive works just like any other debit or credit card, except that it can only be used to pay qualifying Dependent Care Expenses. Thus, the debit card may be used to pay your Dependent Care Expenses at the time the transaction is initiated, while automatically debiting the current balance in your Dependent Care Reimbursement Account with the amount of the payment. However, all Dependent Care Expenses paid by the debit card must be reviewed and substantiated after they are paid to ensure that they qualify for reimbursement under the Plan.

All Dependent Care Expenses paid by the debit card, are conditional until you submit a statement or receipt to the Plan from a qualified dependent care provider. This documentation must show:

- The amount, date and nature of the expense;
- The name of the person or provider that rendered the services if they were rendered in a dependent care center outside the home;
- The signature of the provider if the dependent care is provided in a private home setting;
- Wording indicating the expense was for dependent care;

- The name of the person or persons on whose behalf Dependent Care Expenses have been incurred; and
- Any other information that the Plan may reasonably require.

You must submit this documentation, along with a Receipt Notification letter or e-mail, to Principal Life Insurance Company at the address indicated in order to obtain approval. You will be notified in writing of any requests that are denied, in whole or in part, or if any additional information is required.

Q-26 How do I file for a reimbursement?

When you incur a qualifying expense, you will need to submit a Request for Reimbursement form along with documentation of the expense. An expense is considered incurred at the time the dependent care services are provided and not when you are charged for, formally billed for or pay for the expense. Only expenses incurred while you are a Participant are eligible. Expenses incurred before your coverage became effective or after your coverage terminated will not be paid. A Request for Reimbursement form can be obtained from your Employer. You must submit your completed request and any required documentation to The Principal at the address shown on the form at least two business days prior to your reimbursement date. The Request for Reimbursement Form must include:

- the name of the person or persons on whose behalf dependent care expenses have been incurred;
- the nature of the expenses so incurred;
- the name of the provider of service;
- the date(s) the service was provided;
- the amount of the requested reimbursement; and
- a signed statement that such expenses have not otherwise been paid and are not expected to be paid through any other source.

The Request for Reimbursement Form shall be accompanied by: bills, invoices, or other statements from the provider of service showing the amounts of such expenses or an explanation of benefits (EOB) from the insurance carrier who processed the claim, together with additional documentation that the Administrator may request.

The amount you contribute for Dependent Care expenses for any Plan Year can be used only to reimburse qualifying child care expenses incurred during that Plan Year. The tax law requires that you forfeit any unused amount.

If you do not have enough credits at the time a reimbursement request is filed, you will be reimbursed for the expense, up to the amount that you have contributed year to date, less any previous reimbursements.

You will be notified in writing of any requests denied, in whole or in part, or if any additional information is required.

Q-27 Do I have to use the Debit Card?

No. If you incur a qualifying Dependent Care Expense and do not want to use your debit card, you will need to submit a Request for Reimbursement form, along with any required documentation, to the Plan to apply for reimbursement for your claim. A Request for Reimbursement form can be obtained from your Employer. You must submit your completed request and any required documentation to Principal Life Insurance Company at the address shown on the form at least two business days prior to your reimbursement date. You will be notified in writing of any requests that are denied, in whole or in part, or if any additional information is required. The same type of claim documentation that is referenced in Q & A 26 is required when submitting a Request for Reimbursement Form, but it does not include a Receipt Notification letter or a copy of an e-mail.

Q-28 What happens if I don't spend everything that I elect to have deducted from my pay?

The amount you contribute to the Plan for Dependent Care Expenses for any Plan Year can be used only to reimburse qualifying Dependent Care Expenses incurred during that Plan Year. The tax law requires that you forfeit any unused amount.

Q-29 What happens if the amount of my claims exceeds the current amount that has been deducted from my pay?

Whether paying Dependent Care Expenses with the debit card or requesting reimbursement by submitting a Request for Reimbursement form to the Plan, the Plan will never pay Dependent Care Expenses in excess of the amount that is currently available in your Dependent Care Reimbursement Account. The amount currently available is the amount that has actually been deducted from your pay for a Plan Year for Dependent Care Expenses on the date the claim is filed less the amount that has previously been paid for a Plan Year. This means that Dependent Care Expenses incurred during the Plan that are in excess of the amount currently available in your Dependent Care Reimbursement Account as of the date they are submitted will not be paid. However, a claim that has not been paid because of this reason, will automatically be held until more money has been deducted from your pay, provided that no money deducted from your pay during one Plan Year is used to pay expenses incurred during another Plan Year. Then, once enough contributions have accumulated in your Dependent Care Reimbursement Account, such unpaid expenses will be reimbursed in the order they were filed.

When using the debit card, it is particularly important to keep track of the amount currently available in your Dependent Care Reimbursement Account to pay for qualifying Dependent Care Expenses, so that you know the Account's current balance when you plan to use your debit card. In the event that you try to use your debit card to pay a Dependent Care Expense that is in excess of the amount currently available in your Dependent Care Reimbursement Account, no payment will be issued and the entire transaction will be denied. However, when requesting reimbursement from the Plan on a Request for Reimbursement form, the Plan will pay the claim up to the amount currently available in your Dependent Care Reimbursement Account, and will deny any remaining expense.

Q-30 When is my reimbursement date?

Reimbursements for claims submitted with a request for reimbursement form are processed Tuesday of each week. If you submit a request for reimbursement after you have incurred a qualifying Dependent Care Expense, your reimbursement will be paid on the Tuesday next following the date your claim is received by Principal. Claims must be received two business days prior to Tuesday in order for your reimbursement to be released on that day. If your claim is received less than two business days prior to Tuesday, your reimbursement will be released on the following Tuesday. Expenses paid with the debit card are reimbursed when the debit transaction is complete.

Q-31 What is the minimum reimbursement amount?

The sum of all qualifying Dependent Care Expenses submitted to the Plan on Request for Reimbursement forms, not including any Dependent Care Expenses paid by the debit card, must equal at least \$25 before the Plan will issue a reimbursement check. If the total of all claims that have been received as of the date they are scheduled for reimbursement is less than \$25, a reimbursement check will not be issued on that date. However, claims that have not been paid because of this reason, will automatically be held until additional expenses are submitted, and then will be considered for payment in the order they were received. This minimum reimbursement policy does not apply to the final reimbursement for any Plan Year. Also, when the debit card is used, there is no minimum payment for qualifying Dependent Care Expenses.

Q-32 What is the timing to submit claims following the end of the Plan Year or a termination?

All claims for reimbursement of qualifying Dependent Care Expenses incurred during the Plan Year must be received by the Claim Administrator no later than the 90th day following the end of the Plan Year. Once a Plan Year ends the debit card cannot be used for expenses incurred during that Plan Year. If contributions remain in your Dependent Care Reimbursement Account after a Plan Year ends, and you have incurred additional Dependent Care Expenses during that Plan Year, those expenses must be manually submitted with a completed FSA Request for Reimbursement form and a itemized receipt. The debit card will be loaded with the new Plan Year Dependent Care contribution amounts (if any) and will be activated at the beginning of the new Plan Year.

Once the balance has been loaded to the debit card for the upcoming Plan Year and the new Plan Year begins, the debit card must be restricted to Dependent Care Expenses incurred during that Plan Year only. In the event that you use your new debit card to pay Dependent Care Expenses incurred in a prior Plan Year, you will receive notification of the error from the Plan, and will be required to refund the amount that was paid by the debit card.

If your participation terminates at any time during the Plan Year, all claims for reimbursement of qualifying Dependent Care Expenses incurred on or prior to your termination date must be received by the Claim Administrator no later than the 90th day following your termination date. However, once your employment ends, your debit card will be permanently deactivated. If contributions remain in your Dependent Care Reimbursement Account after your employment ends, and you have incurred additional Dependent Care Expenses prior to your termination date, you must submit a Request for Reimbursement form and any required documentation to the Plan in order to apply for reimbursement. Expenses incurred after your coverage ends are not reimbursable.

Q-33 What happens if a claim for benefits is denied?

Notification of approval or denial

The Claim Administrator shall provide to any claimant whose claim is denied, written notice setting forth, in a manner calculated to be understood by the claimant, the following:

- The specific reason or reasons for the denial; and
- Specific reference to pertinent plan provisions on which the denial is based; and
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- An explanation of the Plan's claim review procedure, as set forth below.

Review Procedure

The purpose of the review procedure set forth in this paragraph and below is to provide a procedure by which a claimant under the Plan may have a reasonable opportunity to appeal a denial of a claim and request a full and fair review. To accomplish that purpose, the claimant or a duly authorized representative may by written request to the Claim Administrator:

- Request a review; and
- Review pertinent plan documents or agreements; and
- Submit issues, comments, and added facts in writing.

Decision on Review

The decision on review shall be made by the Plan Administrator. The decision shall not ordinarily be made any later than 60 days after the Plan's receipt of the request for review.

The decision on review shall be in writing and shall include specific reasons for the decision and a specific reference to the pertinent Plan provisions on which the decision was based, written in a manner calculated to be understood by the claimant.

Reimbursement of Debit Card Payments

If a claim that has already been paid by the debit card is determined not to qualify for payment under the Plan after review, or if the Plan does not receive the documentation required to substantiate a Dependent Care Expense paid by the debit card, the Plan will inform the Participant of the improper payment and may:

- Require the Participant to refund the amount that was paid;
- Deduct the improper payment from the Participant's future paychecks;
- Reduce payment of future claims by the amount of the improper payment; or
- Inactivate the card until the refund is received.

All refunds for improperly paid claims must be sent to the Plan prior to the end of the Plan Year within which the refund was requested.

Q-34 How do I appeal a denied claim?

You or your authorized representative may submit in writing within 180 days of notice of denial:

1. a request for claim review;
2. to review pertinent plan documents or agreements; and
3. submit issues, comments, and added facts.

The request for review should be submitted to the Plan Administrator.

Q-35 What if it is determined a reimbursement was made in error or a claim had been overpaid?

If a claim that has already been paid is later determined not to qualify for reimbursement or is determined to have been overpaid you will be notified of the improper payment and may be required to refund the amount that was paid or overpaid. Or, you may be required to reduce payment of future reimbursement by the amount of the improper payment.

All refunds for improperly paid claim must be sent to the Plan prior to the end of the Plan Year in which the refund is requested

Q-36 What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable Compensation. Accordingly, there could be a slight decrease in your Social Security benefits or other benefits (e.g., pension, disability and life insurance) which are based on taxable Compensation.

Q-37 What is the Family and Medical Leave Act?

If your Employer is subject to the Family and Medical Leave Act (FMLA) (generally, employers with at least 50 employees are subject to such) and if you are on eligible leave under FMLA, then you may continue to pay your Dependent Care Reimbursement Account contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer;
- with pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium, you must make a special election to that effect prior to the date that such Compensation would normally be made available (note, however, that pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between you and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return).

If you elect to terminate coverage during the leave, the debit card will be temporarily inactivated during the period of leave, and then reactivated following return from leave if you elect to re-enter the Plan on such date. If your Employer is subject to FMLA, then you should be provided with a complete explanation of your FMLA rights and responsibilities.

**PART II. ELECTING LESS THAN
THE MAXIMUM ANNUAL BENEFIT**

Any portion of your Compensation that you do not choose to apply toward the purchase of the benefits described above will be paid to you as regular, taxable Compensation.

PART III SUPPLEMENTAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

Drake University Section 125 Pre-tax Salary Reduction Dependent Care Reimbursement Plan is the name of the Plan.

Your Employer has assigned Plan Number 503 to your Plan.
Your Employer's EIN is 42-0680460-001.

The provisions of the Plan described herein became effective June 1, 2001.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year.

The first Plan Year begins on June 1, 2001 and ends on May 31, 2002. Thereafter, the Plan Year is every year beginning June 1st and ending on May 31st of the following year.

2. Employer and Plan Administrator Information

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

Drake University
2507 University Avenue
Des Moines, IA 50311-4505

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

3. Claim Administrator

Principal Life Insurance Company
1275 NW 128th St., Suite 100
Clive, IA 50325
Telephone: (515) 273-9298

4. Service of Legal Process

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

Drake University
2507 University Avenue
Des Moines, IA 50311-4505

Legal process may also be served upon the Employer and Plan Administrator. Legal process may not be served upon the Plan Claim Administrator.

5. Minimums and Maximums

Employee Salary Reduction Contributions

The maximum amount you may contribute to this option each Plan Year is \$5,000.00 (\$2500.00 if you are married and filing a separate tax return). The minimum amount you may contribute is \$300.00.

6. Plan Fiduciary

Drake University

7. Additional Plan Information

Addendum

Addendum
Related To Employers That Have Adopted This Plan,
With the Approval of Drake University

None