

DRAKE UNIVERSITY

**SECTION 125 PRE-TAX SALARY REDUCTION
HEALTH 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 Health 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 and ERISA.

PART I. GENERAL INFORMATION **ABOUT THE HEALTH 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 out-of-pocket Health Care Expenses with pre-tax dollars.

Q-2 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 Health 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.

Q-3 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 Health Care Expenses when they are incurred, up to the amount of your annual benefit election. It automatically filters companies by their merchant category codes, so that it can only be used at pharmacies and health care providers. All Employees who elect to participate in the Plan are eligible to participate in this debit card program.

Q-4 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 a common-law employee who is on the Employer’s W-2 payroll, except that the term “Employee” does not include any common-law employee who is a leased employee (including but not limited to an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is 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 to be common-law employees of the Employer. The term “Employee” includes “former employees” for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by 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, when COBRA coverage ends);
or
- the date the Participant revokes his or her election in accordance with Q-8.

Q-5 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 Health Care Expenses is \$140.00 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage 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 Health Care Expense. 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 Health 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 Health Care Expense	<u>- 0.00</u>	<u>-140.00</u>
Take Home Pay	<u>\$1,825.00</u>	<u>\$1,794.00</u>

Q-6 How do I become a Participant?

Employee Salary Reduction Health Care Reimbursement Account

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 fail to complete, sign and file an Election Form as required you will not participate 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-7 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-8 Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Pre-Tax Health 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 employee benefit plan (including the Health Insurance 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;
- *HIPAA:* Special enrollment rights for loss of other Health Coverage only apply if the Health Care Reimbursement Account is subject to HIPAA;
- *Certain Judgments, Decrees or Orders:* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation or annulment results in a change in custody of a Dependent; or
- *Entitlement to Medicare or Medicaid:* If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, or if you, your

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 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-9 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-10 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-11 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-12 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-13 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-14 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-15 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-16 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 cards 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 Health Care Expenses; and
- That you will retain the required documentation for any expense that is paid by the debit card.

Q-17 What expenses can I pay with Plan benefits?

You can pay expenses incurred by you or your Dependents for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of aiding any structure or function of the body, but only to the extent that the expenses are not paid or reimbursable by any insurance policy or through some other source. Here are some examples of the kinds of expenses that may qualify:

Dental Care
Dentists
Orthodontists

Health Plan Expenses
Copayments
Deductibles

Medical Transportation
Ambulance
Taxi To Doctor

Diagnostics/Treatment
Annual Checkups
Acupuncture
Chiropractors
X-Rays, Surgery

Hearing and Vision Care
Eye Exams
Hearing Aids & Tests
Optometrists
Refractive Eye Surgery,
Contact Lenses &Glasses

Mental Health
Alcohol/Drug Treatment
Halfway House
Hypnosis

Disability Aids

Braille Materials
Car Controls
Guide Dogs
Telephone for the deaf

Medical Equipment/Supplies

Crutches & Wheelchairs
Lancets and Syringes
Orthopedic Shoes
TENS Unit

Miscellaneous

Over-The-Counter Drugs
Prescription Drugs
Reproductive/Birth Control
Weight Loss Program Fees

These are only some examples of qualifying expenses; it is not intended to be a complete list. It is possible that some items currently on the list will not be regarded as qualifying expenses in the future due to changes in the law or in its interpretation.

Q-18 What expenses are not considered to be eligible medical care expenses?

Medical Care Expenses do not include:

- qualified long term care services as defined by the Internal Revenue Service.
- any product which is advertised, marketed, or offered as long term care insurance.
- health, exercise or weight loss programs, except when prescribed by a physician as medically necessary to treat an existing illness or injury.
- over-the-counter vitamins, supplements and herbs, unless prescribed by a physician for treatment of a specific, diagnosed medical condition.
- amounts reimbursed by any other health plan, insurance policy or other source.
- premiums for another health plan or insurance policy.
- cosmetic teeth bleaching.
- hair loss remedies, including Propecia and Rogaine.
- massage therapy, unless prescribed by a physician to treat a specific illness or injury.
- cosmetic surgery, or other cosmetic procedures directed mainly at improving the patient's appearance and that do not meaningfully promote the proper function of the body, prevent, or treat illness or disease unless medically necessary to correct a congenital deformity or abnormality or result of a personal injury from an accident or trauma or a disfiguring disease.
- any other service or supply that does not qualify as medical care for federal income tax purposes.

Q-19 Who are considered my Dependents for purposes of this Plan?

A person's status is determined on a yearly basis. Your Dependents include your Spouse and:

- any person whom you can claim as a dependent for federal income tax purposes; and
- any person whom you could claim as a dependent for federal tax purposes but for the fact that:
 1. you were a dependent of another person during the year; or
 2. the person was married and filed a joint return for the year

Your Spouse is a person of the opposite sex to whom you are legally married.

Q-20 How are my Premium Payments made?

Salary Reduction Premium Payments

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

Q-21 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 Health Care Reimbursement Account when your employment ends, you may still receive reimbursements for Health 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 a former Participant who is rehired more than 30 days following termination of your employment and you are otherwise eligible to participate in the Plan, 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-22 Will I pay any administrative costs under the Plan?

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

Q-23 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-24 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 Health Care Expenses. Thus, as long as your Health Care Expenses are incurred at a pharmacy or a health care provider, the debit card may be used to pay for them at the time the transaction is initiated, while automatically debiting your annual benefit election with the amount of the payment. However, all Health 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. Health Care Expenses are considered to be fully substantiated at the time of the transaction, without the need for further review or for submission of a receipt, if:

- The dollar amount of the transaction equals the dollar amount of the copayment for that service under your Employer's Health Insurance Plan; or
- The dollar amount and provider name associated with a Health Care Expense exactly match those associated with a previously approved and reimbursed Health Care Expense under the Plan, indicating that the claim is for a recurring expense.

For all other Health Care Expenses paid by the debit card, the Plan's payment is conditional until you submit a statement or receipt to the Plan from a pharmacy or a health 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;
- The name of the person or persons on whose behalf Health 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-25 Do I have to use the Debit Card?

No. If you incur a qualifying 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.

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 health 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 health 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 Health Care expenses for any Plan Year can be used only to reimburse qualifying medical 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 maximum amount that you have allocated to the Plan for the entire Plan Year, even if you have not yet made all your annual contributions.

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

Q-27 What happens if I don't spend everything that I elect to have deducted from my pay?

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

Q-28 What happens if the amount of my claims exceeds the current amount that has been deducted from my pay?

Employee Salary Reductions

Whether paying Health Care Expenses with the debit card or requesting reimbursement by submitting a Request for Reimbursement form to the Plan, the Plan will never pay any Health Care Expenses in excess of the amount that is currently available in your Health Care Reimbursement Account. The amount currently available is the amount of your annual benefit election for Health Care Expenses, less the amount already paid to you in claims from your Health Care Reimbursement Account. This means that Health Care Expenses incurred during the Plan Year, even if in excess of the amount that has actually been deducted from your pay, will be paid as they are filed up until the maximum amount that you elected for the entire Plan Year has been exhausted.

When using the debit card, it is particularly important to keep track of the amount currently available to you in your Health Care Reimbursement Account to pay for qualifying Health 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 Health Care Expense that is in excess of the amount currently available in your Health 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 Health Care Reimbursement Account, and will deny any remaining expense.

Q-29 When is my reimbursement date?

If you submit a request for reimbursement after you have incurred a qualifying Health Care Expense, your reimbursement date(s) will be weekly on Tuesdays of each month. Health Care Expenses paid with the debit card are reimbursed when the debit transaction is complete.

Q-30 What is the minimum reimbursement amount?

The sum of all qualifying Health Care Expenses submitted to the Plan on Request for Reimbursement forms, not including any Health 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 Health Care Expenses.

Q-31 What is the timing to submit claims following the end of the Plan Year or a termination?

All claims for reimbursement of qualifying Health Care Expenses incurred during the Plan Year must be received by the Administrator or the Administrator's designee 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 Health Care Reimbursement Account after a Plan Year ends, and you have incurred additional Health Care Expenses during that Plan Year, those expenses must be manually submitted with a completed FSA Request for Reimbursement form and an itemized receipt. The debit card will be loaded with the new Plan Year annual election (if any) and will be activated at the beginning of the new Plan Year.

If your participation terminates at any time during the Plan Year, all claims for reimbursement of qualifying Health Care Expenses incurred on or prior to your termination date must also be received by the Administrator or the Administrator's designee no later than the 90th day following your termination date. However, once your employment ends, your debit card will be permanently inactivated. If contributions remain in your Health Care Reimbursement Account after your employment ends and you have incurred additional Health 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. Refer to Q-26 for details on required documentation.

Q-32 What happens if a claim for benefits is denied?

Notification of approval or denial

If your claim for a welfare benefit is denied, 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.

The Claim Administrator shall provide to any claimant who is denied a claim, 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, within 180 days of the notice of denial, 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, which may in its discretion hold a hearing on the denied claim. 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 Health 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-33 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-34 What is COBRA?

COBRA is a federal law which applies to employers who have 20 or more employees and who sponsor group health plans. It requires these employers to offer Participants and their family members who lose their health coverage under certain circumstances an opportunity to extend that coverage. This is called continuation of coverage.

Q-35 When may I elect COBRA continuation of coverage?

You or your Dependents may elect to continue Plan coverage under COBRA for the remainder of the Plan Year, but only if:

- you lose coverage because of a Qualifying Event, as explained below; and
- the maximum remaining benefit available is more than the maximum amount that the Flexible Benefits Plan could require you to pay to keep coverage under the Plan for the rest of the Plan Year.

For example, assume your annual election under the Plan is \$1,200, resulting in a payroll deduction of \$100 per month. At the end of March, after you have paid \$300 in Plan premiums, your employment ends due to a Qualifying Event. In addition, you have incurred only \$100 in claims. In such a case, since the maximum remaining benefit available ($\$1,200 - \100 or $\$1,100$) is more than the maximum amount that the Flexible Benefits Plan could require you to pay to keep coverage under the Plan for the rest of the Plan Year ($\$1,200 - \300 or $\$900$, plus 2% of $\$900$ or $\$18$, for a grand total of $\$918$), the Plan must offer you COBRA coverage.

Q-36 What is a Qualifying Event?

The following are considered Qualifying Events:

- A. You will have a Qualifying Event and may elect continued coverage if your employment ends (for reasons other than gross misconduct) or if your hours are reduced so that you are no longer eligible for coverage under this Plan.
- B. Your spouse and dependent children will have a Qualifying Event and may each elect continued coverage if their coverage ends because your employment ends or your hours have been reduced.
- C. Your spouse and dependent children will also have a Qualifying Event and may each elect to continue coverage if they would otherwise lose coverage because of:
 - your death;
 - your divorce or legal separation;
 - your eligibility for Medicare; or
 - your Dependent ceasing to be a dependent child.

Also, a child born to you, adopted by you or placed for adoption with you during a period of COBRA continuation coverage may elect continued coverage.

Q-37 Has A Qualifying Event occurred if I take an FMLA leave?

No, commencement of FMLA leave is not a Qualifying Event for purposes of COBRA. However, a COBRA Qualifying Event will occur on the earlier of:

- the date FMLA leave ends, unless you return to work as required by the Employer; or
- the date you notify the Employer that you will not return to work after FMLA leave ends.

You and your Dependents may elect COBRA continuation coverage for an FMLA-related Qualifying Event, even if you did not continue coverage during the FMLA leave.

Q-38 What notice must I give to continue coverage?

The Plan requires Qualified Beneficiaries (or someone acting on their behalf) to notify the Plan Administrator when any of the following qualifying events occurs in order to obtain COBRA continuation coverage:

- the divorce or legal separation of you and your spouse.
- an event that causes a dependent child to lose eligibility.

The notice must be in writing and sent by first class mail to the Plan Administrator at the employer's address.

The notice must include the name and social security number of each Qualified Beneficiary, the type of Qualifying Event, the date of the Qualifying Event and the name, address and daytime phone number of a person that the Plan Administrator can contact if additional information is needed to determine the person's COBRA rights.

The notice must be postmarked no later than 60 days after the latest of:

- the date of the Qualifying Event;
- the date the Qualified Beneficiary would lose coverage as a result of the Qualifying Event; or
- the date you and/or your spouse is informed of this notice obligation through the furnishing of this SPD.

Q-39 How do my dependents or I elect continued coverage?

Within 14 days of the date it receives notice of a Qualifying Event, the Plan Administrator will give written election notice to Qualified Beneficiaries of the right to continuation of coverage. When the Employer and Plan Administrator are the same, Qualifying Events based on your termination of employment, reduction in hours, the death or Medicare entitlement, the *plan administrator* will have 44 days from the date of the Qualifying Event (or loss of coverage where applicable) to provide this notice.

The notice will state the amount of premium required for the continuation of coverage. If the Qualified Beneficiary wants continuation coverage, then he must complete and return the election notice within 60 days of the later of:

1. the date the coverage would otherwise have ended; or
2. the date of the notice informing the person of the right to continue.

Q-40 How long does this continued coverage last?

The maximum period of continued coverage is through the end of the Plan Year in which the Qualifying Event occurs.

Continued coverage will end before the maximum period of coverage expires for a person receiving continued coverage when any of the following events occurs:

- A. the Employer ceases to provide a medical care expense benefit to any employee.
- B. the date coverage ceases because of failure to pay the premium.

- C. the date the covered person becomes covered under another group health plan which does not contain any exclusion or limitation that applies to a pre-existing condition of that person.

Q-41 What benefits will I receive under COBRA continuation coverage?

Benefits under continuation coverage will be paid according to the provisions and limitations of the Flexible Benefits Plan in force on the date services are rendered.

Q-42 What is the premium for continued coverage and when must it be paid?

The premium for continued coverage under the Plan is normally 102 percent of the amount that would be deducted from your compensation for the same coverage. If you and your Dependents make separate elections to continue coverage, then the premium for each person electing coverage will be 102 percent of the amount that would be deducted for the same coverage.

If a person elects COBRA continuation, he must pay the premium for the "initial premium months" by the 45th day after the date of the election. The initial premium months are the months that end on or before the 45th day after the date of the election. COBRA coverage will become effective back to the date of the loss of coverage upon timely receipt of the initial premium.

Q-43 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-44 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 Health 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.

Q-45 What is the Uniformed Services Employment and Reemployment Rights Act (USERRA)?

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Flexible Spending Account under USERRA. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

**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. ERISA RIGHTS

As a participant in the Pre-Tax Salary Reduction Health Care Reimbursement 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 shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office, Drake University, 2507 University Avenue, Des Moines, IA 50311-4505, and at other specified locations, such as worksites 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.

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.

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.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including 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 (pension, welfare) benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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.

ASSISTANCE WITH YOUR QUESTIONS

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART IV. 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 Health 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 Record Keeper.

5. Minimums and Maximums

Employee Salary Reduction Contributions

The maximum amount you may contribute to this option each Plan Year is \$3,600.00.

The minimum amount you may contribute to this option each Plan Year is \$120.00.

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