

PLAN PURPOSE  
Lane Community College  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION

The Lane Community College Flexible Benefits Plan is a benefit program that allows you to use pretax benefit dollars through payroll deduction to pay for insurance premium(s), unreimbursed medical expenses, and dependent care expenses. Section 125 of the Internal Revenue Code permits Lane Community College to offer you the opportunity to participate in designing your own personalized benefit plan on a tax-favored (pretax) basis. This Summary does not describe every detail of the Flexible Benefits Plan. If there is a conflict between the Plan Document and the Summary, the Plan Document will control.

**WHO IS ELIGIBLE TO ENROLL IN THE PLAN**

If you are an employee, your eligibility is the same as the health insurance, as indicated in CBA or MWC for Lane Community College ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

For purposes of the Premium Only Plan Module your spouse or dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your spouse or dependent(s) cannot participate in the Plan independently.

Self-employed individuals, including sole proprietors, partners in a partnership and more than 2% shareholders in an s-corporation are not eligible to participate in the Plan, however C Corporation owners who are also W2 employees can participate.

**HOW TO ENROLL**

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect (or within 30 days of becoming eligible for employees who become eligible during a Plan Year). Each year, Lane Community College will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your salary reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible (your normal paycheck will not be voluntarily reduced). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, then you will be able to maintain the medical and dental benefit options, if any, that you elected for the prior year, but will not be eligible to participate in either the Health FSA or the Dependent Care Assistance Plan (DCAP) (the Health FSA and DCAP are called the "Spending Accounts").

You may build a completely new plan each year. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the next Plan Year.

**WHEN YOU ARE ELIGIBLE TO ENROLL**

As an eligible employee, your eligibility is the same as health insurance, as indicated in CBA or MWC.

**SCHEDULE OF FLEXIBLE BENEFITS**

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by Lane Community College on the enrollment form and outlined in Schedule C and Schedule D of this Summary Plan Description.

The benefits from which you may choose include:

- medical plan(s) outlined in Schedule A

- health savings account (HSA) contributions
- two different spending accounts:
  - a Health Flexible Spending Account (Health FSA)
  - a Dependent Care Assistance Plan Flexible Spending Account (DCAP)

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the plan documents that have been prepared solely for the purpose of each particular benefit. A copy of all this information is available from Darcy Dillon at Lane Community College.

## OPTIONAL BENEFITS

Briefly, the Optional Benefits from which you may choose are as follows:

### 1. Health Insurance Plan(s)

You may purchase the health insurance coverage for yourself and your family through the Flexible Benefits Plan. You may pay your required contribution for this coverage using pretax dollars that are automatically deducted per pay period. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

### 2. Flexible Spending Accounts (FSAs)

There are some expenses you know you'll have to pay for in the coming year; for instance, new eyeglasses, medical and dental care expenses not covered by the health plan, or perhaps care for a child or an incapacitated dependent adult while you are at work. Normally you would pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn considerably more than \$100 to pay for \$100 of expenses.

If you are eligible to participate, the Lane Community College Flexible Benefits Plan allows you to contribute pretax income to create special accounts in order to reimburse yourself on a pretax basis for payment of certain medical and dependent care expenses. It is like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to spending accounts by automatic payroll deduction is not subject to federal or Social Security taxes but, depending on your residence, may be subject to state and local income taxes.

### *How Health FSAs and Dependent Care Assistance Plan Spending Accounts Work*

You may establish spending accounts for two separate categories of predictable expenses –medical care and dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a per pay period basis to the spending account you have elected. The minimum amount you may defer is \$120.00 per Plan Year. The maximum pretax deferral for the Health FSA and for the Dependent Care Assistance Plan is outlined in Schedule D attached to this Summary. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the Benefits Administrator of Lane Community College or the designated claims administration representative. Once the claims administrator receives the claims all claims will be processed for reimbursement on a monthly basis. Upon submission of a claim to your Health FSA, you will be reimbursed the full amount of your eligible expenses up to your elected Health FSA pretax deferral amount. However, you must have accumulated a sufficient credit balance in your Dependent Care Assistance Plan in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent months as more dollars are contributed from your pay to your Dependent Care Assistance Plan. If the Health FSA and/or Dependent Care Assistance Plan is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by your Plan Administrator in accordance with IRS guidance. You must acquire and retain sufficient documentation to substantiate any expense paid with the debit card.

### *The Health FSA*

Under this category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary," with substantiated

claims and allowable as deductions under Code Section 213. Covered expenses do not include premiums paid for other health plan coverage, including plans maintained by the employer of your spouse or dependents, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage. More detailed information about what is eligible and what is not eligible for reimbursement will be provided later in this Summary. Reimbursable "Medical Care Expenses" will vary depending on which Health FSA coverage option you elect (you must participate in the elected option for the entire Plan Year). If you participate in an HSA plan you can only participate in the Limited Health FSA option covering dental and vision expenses as outlined below. The following three options outline the definition of "Medical Care Expenses" as they relate to the General Purpose, Limited or Post Deductible options, and

Employee Only Health FSA plans options:

- *General-Purpose Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d)-provided, however, that this term does not include expenses that are excluded under Schedule E to this Summary, nor any expenses for which you or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e. g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.
- *Limited (Vision/Dental/Preventive Care) & Post Deductible Health FSA Option.* This is the only Health FSA option available to employees participating in a Health Savings Account.

For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d)-provided, however, that such expense is for vision care or dental care) only, and provided that this term does not include expenses that are excluded under Schedule E to this Summary, nor any expenses for which you or other person incurring the expense is reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan. Once the HSA Plan deductible has been met "Medical Care Expenses" shall mean post deductible expenses incurred by you or your Spouse or Dependents for medical care as defined in Code § 213(d). The Post Deductible Health FSA option allows you to be reimbursed for qualifying medical expenses outlined in IRS Code 213(d) in excess of high deductible of the qualifying HSA insurance plan. Health Savings Accounts (HSA) Benefits cannot be elected with Health FSA Benefits unless the Limited Health FSA Option is selected (reimburses only Vision/Dental or Post Deductible expenses).

- *Employee-Only Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by you (but not by your Dependent or Spouse) for medical care as defined in Code § 213(d)-provided, however, that this term does not include expenses that are excluded under Schedule E to this Summary, nor any expenses for which you are reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.

You must determine before the Plan Year starts which plan you elect and how much you will likely spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

- *Employee Plus Child Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by you and your Dependent (but not your Spouse) for medical care as defined in Code § 213(d)-provided, however, that this term does not include expenses that are excluded under Schedule E to

this Summary, nor any expenses for which you are reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.

You must determine before the Plan Year starts which plan you elect and how much you will likely spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

#### *The Dependent Care Assistance Plan Spending Account*

Dependents are defined for this purpose as children up to age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return. If dependent care is required to enable you (or a spouse or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools and payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a nonrelative, as long as such a person is reporting payments as income, is also eligible.

Be aware that you may be able to take a federal tax credit for eligible expenses up to \$3,000 (for one dependent) or \$6,000 (for more than one dependent). The credit equals 35% of expenses, reduced by one percentage point (but not to drop below 20%) for each \$2,000 (or fraction) by which your adjusted gross income exceeds \$15,000. Any amounts deferred to a Dependent Care Spending Account will reduce dollar-for-dollar the maximum allowable expense under the tax credit. This can be confusing, you may want to consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

#### *Spending Accounts - Other Facts to Consider*

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible spending accounts:

- Pre-tax contributions that you authorize for medical and dependent care expense reimbursement are in effect for the entire year unless you have a change in status such as those listed under "Election Changes" in this Summary Plan Description.
- You must use all of the funds in your Spending Accounts by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to contribute to Health FSA or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses.
- You may request statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims up to 90 days after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given 90 days after Plan Year-3/31/14 days from their date of termination in which to submit expenses incurred prior to their termination for remaining Health FSA benefits. However a spend-down provision applies to the Dependent Care FSA that will allow you to use up your remaining benefits prior to the end of the Plan Year. You will be given 90 days from the end of the Plan Year to submit claims incurred for your Dependent Care Assistance Plan.

#### **ELECTION CHANGES**

You generally cannot change your election to participate in this Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule, known as "Change in Election Events." Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Changes in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Certain Judgments, Decrees, and Orders;

Medicare and Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits – applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. A special HIPAA enrollment period of no more than 60 days is provided as of April 1, 2009 for Employees and their Dependents for loss of Medicaid or CHIP Coverage; or upon becoming eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to the Medical Insurance Plan only, not to Health FSA or DCAP enrollment. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence. You may change an election under the Salary Reduction Plan upon FMLA, non-FMLA, and USERRA leaves of absence.
2. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:
  - a. a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code ("the Code");
  - b. a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
  - c. any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefits eligibility under a cafeteria plan (including this Salary Reduction Plan) or other employee benefit plan of you, your Spouse, or your Dependents.

Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

- d. an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance).
  - e. a change in your, your Spouse's or your Dependent's place of residence.
3. 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 and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.



For example, assume that you elected to contribute \$100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of \$700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of \$700 for the year. In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (applies to Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Salary Reduction Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
  - *DCAP Benefits.* With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.
4. *Special Enrollment Rights. (Applies to Medical Insurance Benefits, but Not to Health FSA or DCAP Benefits.)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under the Salary Reduction Plan to correspond with the special enrollment right.
  5. *Certain Judgments, Decrees, and Orders. (Applies to Medical Insurance Benefits and Health FSA Benefits, but Not to DCAP Benefits.)* If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.
  6. *Medicare or Medicaid. (Applies to Medical Insurance Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under Medicaid. The 60 day special enrollment period applies to the Medical Insurance Plan only, not to Health FSA enrollment.

7. Eligibility for Premium Assistance Subsidy. *(Applies to Medical Insurance Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy. The 60 day enrollment period applies to Insurance Plans only, not to Health FSA enrollment.
8. Change in Cost. *(Applies to Medical Insurance Benefits, and to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If the cost charged to you for your Medical Insurance Benefits or DCAP benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; (b) an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and (c) coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage).

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases in the cost of DCAP benefits. The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

9. Change in Coverage. *(Applies to Medical Insurance Benefits and DCAP Benefits, but Not to Health FSA Benefits.)* You may also change your election if one of the following events occurs:
  - a. *Significant Curtailment of Coverage.* If your Medical Insurance Benefits or DCAP benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage, then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage).
  - b. *Addition or Significant Improvement of Salary Reduction Plan Option.* If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
  - c. *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under CHIP.
  - d. *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.

- e. *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.
10. **Change in HSA Elections.** If you have enrolled in the Health FSA Plan during Open Enrollment and have elected HSA Benefits, you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. *However, no other benefits package option election changes can be made as a result of a change in your HSA Benefits election.*

For example, generally you would *not* be able to terminate or change an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

11. **Modifications Required by the Plan Administrator.** The Plan 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 Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Salary Reduction Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

#### MEDICAL CARE EXPENSES THAT MAY BE REIMBURSED FROM THE HEALTH FSA

For Health FSAs, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" now includes expenses for over-the-counter (OTC) drugs and medicines that are prescribed by a physician, as well as expenses for prescription drugs. Your Health FSA Account may reimburse reasonable quantities of over-the-counter (OTC) medical care items of the same kind purchased in a single calendar month; stockpiling is not permitted.

Schedule E of this Summary specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions on Schedule E will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

For more information about what items are-and are not-Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible. (For example, Health FSAs may reimburse OTC drugs that are prescribed by a physician if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)



Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

#### **FMLA LEAVES OF ABSENCE *(Applicable to groups of 50+ employees)***

If you go on a qualifying leave under the Federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave. If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

#### **NON-FMLA LEAVE OF ABSENCE**

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

#### **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT**

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any benefit offered under this

Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator or may elect to continue coverage as described below. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

Instead of revoking coverage under the Medical Insurance Plan, a Participant may elect to continue participation in the medical benefits available under the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to make any required premium payments or until the Participant fails to apply for reinstatement or to return to employment with the Employer in the time required by USERRA. The Participant shall be responsible for making the required premium payments during the period during which he or she is in "uniformed service". The manner in which such payments are made shall be determined by the Plan Administrator,

#### ABOUT TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

#### FUTURE OF THE FLEXIBLE BENEFITS PLAN

The Flexible Benefits Plan is based on Lane Community College' understanding of the current provisions of the Internal Revenue Code. Lane Community College reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

#### QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including the Medical Insurance Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order will outline certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

#### MATERNITY AND NEWBORN COVERAGE

Since this Plan could offer maternity and newborn coverage under the Health FSA and one or more of the Health Insurance Plans), you are advised that under Federal law, this Plan and the insurers may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

#### YOUR PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines Protected Health Information (PHI) as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment of the provision of health care to a participant; and that identifies the participant or for which there

is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to this plan and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provide that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan Administration Purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has dis-enrolled from the Plan.

With respect to PHI disclosed by The Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.
2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIP AA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the employer.

The employer shall allow only the PHI Officer and other designated persons, access to PHI. These specified employees, or classes of employees, shall only have access to and use PHI to the extent necessary to perform the Flexible Benefits Plan administration functions that the Plan Administrator performs for the Plan. Any of these specified employees who do not comply with the provisions of this Section, shall be subject to disciplinary action by the employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

#### COBRA CONTINUATION COVERAGE *(Generally applicable to groups of 20+ employees)*

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

continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

- (a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.
- (b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.
- (c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

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

*"Medicare"* means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

Note: COBRA provides limited continuation coverage under the Health FSA and does not apply to Dependent Care Assistance Plans. A spend-down provision applies to balances remaining in these accounts through the end of the Plan Year, provided a claim is submitted within 90 days of the end of the Plan Year.

#### COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA).

#### STATEMENT OF ERISA RIGHTS (applies to Health FSA only and Medical Insurance Benefits)

As a Participant in the 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 are entitled to:

##### Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, 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 Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 participants in the Plan, you are entitled to 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

During any Plan Year in which the Employer is subject to COBRA, you are entitled to 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. You are also entitled to review this summary plan description and the documents governing your COBRA continuation coverage rights.

You are entitled to reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the 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, 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 any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

### 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### Enforce Participant's Rights

If your claim for a welfare 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 from the Plan and do not receive them within 30 days, you may file suit in 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 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 federal court. The court shall 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 Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.



The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. Your specific rights to benefits under the plan are governed solely, and in every respect, by the Lane Community College Flexible Benefit Plan Document, a copy of which is available from Darcy Dillon upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

#### Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and Lane Community College or a Participating Employer. Lane Community College' rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

#### Plan Definition and Funding

This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a "welfare" plan, and a Section 129 Dependent Care Flexible Spending Account. The Plan is funded by employee contributions.

#### General Information

- Name: Lane Community College Flexible Benefits Plan (511)
- Plan Number: 511
- Effective Date: 01/01/2013
- Plan Year: 01/01/2013 to 12/31/2013

#### Type of Plans

- Section 125 Premium Only Plan
- Health Flexible Spending Account
- Dependent Care Assistance Plan

#### Participants

The plan provides benefits for all employees of Lane Community College who meet the eligibility requirements described herein.

#### Employer/Plan Sponsor Information

Lane Community College  
4000 E 30th Ave  
Eugene, Oregon 97405  
Phone: 541-463-5589  
Employer Identification Number (EIN): 93-0546223

#### Plan Administrator Information

Polestar Benefits, Inc.  
412 Jefferson Parkway, Ste. 202  
Lake Oswego, OR 97035  
Phone: 855-222-3358

#### Named Fiduciary and Agent for Service of Legal Process

Lane Community College  
4000 E 30th Ave  
Eugene, Oregon 97405

INTRODUCTION  
Lane Community College  
FLEXIBLE BENEFITS PLAN  
QUESTIONS AND ANSWERS

As part of our efforts to keep your medical benefit costs as affordable as possible, Lane Community College (referred to in these questions and answers as the "Company") is pleased to sponsor the Lane Community College Flexible Benefits Plan (the "Plan").

The Plan provides each eligible employee with the opportunity to set aside part of his or her pay on a *pre-tax* basis to:

- (1) pay for his or her share of health insurance premiums under the health care program(s) sponsored by the Company; and,
- (2) provide for reimbursement of unreimbursed medical and dental expenses on a *tax-free* basis; and,
- (3) provide for reimbursement of eligible dependent care expenses you may incur as a result of work.

The Plan helps you because the benefits you elect are nontaxable. In addition, you save Social Security and income taxes on the amount of your salary reduction used to pay for these expenses. Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is *your* benefit, and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan documents or summary plan description for more details. Or, contact Darcy Dillon at Lane Community College.

#### QUESTIONS & ANSWERS

##### 1. What is the purpose of the Plan?

The purpose of the Plan is to permit eligible employees to elect to defer part of their pay on a pretax basis to defray their health insurance expenses, unreimbursed medical expenses and dependent care expenses.

##### 2. What benefits are offered through the Plan?

Three kinds of benefits are offered under the Plan: a "Premium Only Plan" a "Health Flexible Spending Account (Health FSA)", and a "Dependent Care Assistance Plan (DCAP)." These benefits are explained in more detail below.

##### 3. Who may participate in the Plan?

Your requirements and eligibility are the same as health insurance, as indicated in CBA or MWC for the Company or with any affiliated company that has adopted the Plan, you are eligible to participate in the Plan, the requirements are the same as the health insurance, as indicated in CBA or MWC with the Company. Only C Corporation Owners may participate in the Plan. Sole Proprietors, more than 2% owners of S Corporations and family members, Partners, and LLC owners are specifically excluded from participating by the Internal Revenue Code.

##### 4. What is the Premium Only Plan Benefit?

The Premium Only Plan allows you to pay your share of the health insurance premiums and other ancillary benefits listed on Schedule A with *pre-tax* dollars. If you do not elect to receive pre-tax benefits under the Premium Only Plan, you still will have to pay your share of the health insurance premiums under the Company's health care program(s), but on an *after-tax* basis. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

##### 5. How does the Health FSA Benefit help me?

It is likely that you will have some medical expenses that you will have to pay for in the coming year. For example, you or your family will have medical expenses that are subject to deductible or co-payment limits under the Company's health plan. Or you may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with after-tax income. And, because taxes reduce the value of a dollar, you would have to earn considerably more than \$100 to pay for \$100 of expenses.

The Health FSA Benefit under the Plan permits eligible employees to contribute *pre-tax* income to a Health FSA. The Health FSA will reimburse you on a pre-tax basis for your unreimbursed medical expenses. It is like getting a discount on these bills so you don't have to earn as much to pay for them.

6. How does the Health FSA Benefit work?

Once you have determined your annual predictable medical expenses for the plan year (or part thereof, if you first become eligible to participate in the middle of a plan year), you may elect to defer a portion of your salary into a Health FSA maintained on your behalf. You should take into account your health insurance deductibles and copayments, as well as uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary" as described under Section 213(d) of the Internal Revenue code. Do not take into account premiums paid for health insurance coverage provided by the Company (since this is covered under the Premium Only Plan).

Also, do not take into account other health insurance coverage, such as that of your spouse, or expenses for cosmetic surgery.

7. How much may I contribute to my Health FSA?

The maximum amount you may elect to defer into a Health FSA for a year is outlined in Schedule D attached to this Summary.

8. What is an "eligible expense" under the Health FSA?

An "eligible expense" means any items for which you can claim a medical expense covered under the Code Section 213 (with some limitations, see the Summary Plan Description for complete details) of the Internal Revenue Code. It is an expense for which you have not otherwise been reimbursed from insurance or some other source (including a Health Savings Account).

Please review the list of eligible medical expenses provided in your Lane Community College Summary Plan Description for assistance in determining what is an "eligible expense". See Schedule E for a list of ineligible expenses.

9. May I enroll in the FSA if I enrolled in the company's high deductible health plan and contribute to an HSA? In general, you are not allowed to enroll in both the standard FSA and contribute to an HSA. To eliminate this potential, you may enroll in a "Limited (Dental/Vision) Health FSA" option through which you would be eligible to submit claims for Dental and Vision expenses. When enrolled in a Limited Health FSA you will only be allowed to submit Dental and Vision expenses, along with any expenses incurred AFTER you meet the deductible under the health plan so you will want to be conservative with your benefit election.

10. My spouse is enrolled in a Health Savings Account (HSA) with her employer; may I enroll in the FSA? Since your spouse is enrolled in an HSA, you are not permitted to enroll in the standard HSA and submit claims for your dependents. Claims for your spouse and enrolled children should be submitted to his/her HSA for reimbursement. However, if you (or your children) are not enrolled on your spouse's HDHP, the FSA has two options that allow you to enroll with limited benefits.

1) Employee Only Health FSA option - If you are not enrolled in your spouse's HSA, you may enroll in the FSA under this option to submit eligible claims for yourself (but not for your spouse or children).

2) Employee-Plus-Children FSA option - If you and your children are not enrolled on your spouse's HSA plan, you may enroll under this option and will be eligible to submit claims on you and your children.

On your Enrollment Form, please remember to let us know that your spouse is enrolled in an HSA at her employer and opt for the appropriate FSA option for you.

11. How do I receive medical expense reimbursements under the Plan?

To receive reimbursement, you must complete a claim form and attach any other information as the Plan Administrator may require. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed the full amount of your eligible expenses, up to your elected Health FSA limit.

12. What happens to the money in my Spending Account(s) should I terminate employment?

You may submit claims on expenses incurred before the end of the month, up until 90 days after Plan Year-3/31/14 days after you leave. If applicable, you may elect continuation coverage through COBRA and you may continue to use your Health FSA. Regarding the Dependent Care Assistance Plan you may spend down the unused portion of your account prior to the end of the Plan Year. Funds left unclaimed at year-end will be forfeited.

13. How long do I have after the Plan Year ends to submit my claims?

You will have 90 days after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment from Lane Community College. A terminated employee has 90 days from their date of termination to submit claims incurred in that Plan Year.

14. What else should I know about the Health FSA Benefit?

The IRS imposes certain restrictions on Health FSAs and DCAPs, including the following:

- Authorized salary reductions into your Health FSA and DCAP may not be changed for the rest of the year unless you terminate employment or have a change in status. Changes in status are discussed in detail in the Summary Plan Description.
- You will forfeit all unused funds in your Health FSA and the DCAP at the end of the year. This is the "use it or lose it" rule. Unused balances may not be carried over to the next year or converted to cash. For this reason, you should estimate your anticipated medical expenses for the year *conservatively*.
- You may request periodic statements to remind you how much money is left in your Health FSA and DCAP. As indicated above, these amounts must be used by the end of the year or they will be lost, unless your Employer has adopted a Grace Period, allowing additional time to incur expenses that are reimbursed from the prior Plan Year unused account balances. Claims may be submitted up to 90 days after the end of the plan year in which the expenses were incurred. If you terminate employment, you may submit claims up to 90 days after you terminate employment.

15. What is the maximum amount of salary I can deposit per pay period to a Dependent Care Assistance Plan (DCAP)?

The maximum you may deposit to a DCAP Account is \$416.67 monthly, or \$5,000 per year. If you are married and file separately the maximum amount is \$208.33 per month, or \$2,500 per year.

16. How often will claims be paid under the DCAP?

Claims will be paid each month after you submit them, up to the balance of your account. Portions of your approved but unreimbursed expenses will be paid monthly as your account rebuilds.

17. Who is an "Eligible Dependent" for whom I can claim a reimbursement under the Dependent Care Spending Account?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13 whom you could claim as a dependent on your federal income tax return; any other dependent who is mentally or physically unable to care for himself or herself; or your spouse, if he or she is physically or mentally incapacitated. See the section titled 'Revised Definition of "Dependent" by WFTRA' in this Summary for more information on the definition of Dependents.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Please note that it is not necessary that you have actually paid the amount due for an Eligible Dependent Care Expense - only that you have incurred the expense and that it is not being paid by or being reimbursed from any other source.

18. Will I be taxed on the Dependent Care Assistance Plan benefits I receive?

You will not normally be taxed on your Dependent Care benefits, up to your DCAP Account deferral amount. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification

numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

19. If I participate in the DCAP will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan.

However, the balance of your dependent care expenses not eligible for reimbursement under this Plan, if any, may be eligible for the dependent care credit.

20. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, eligible work-related dependent care expenses as a credit against your federal income tax liability under the Internal Revenue Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one dependent, or \$6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit of \$1,050 for one dependent or \$2,100 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one dependent or \$1,200 for two or more dependents). The maximum 35% rate must be reduced by 1 % (but not below 20%), for each \$2,000 (or any fraction of \$2,000), of your adjusted gross income over \$15,000. If this is too confusing, consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

21. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security (FICA) withholding taxes.

22. Will the Health FSA claims I submit to my plan administrator be kept private?

Yes, HIPAA Rules require that Protected Health Information (PHI) given to the plan administrator be kept completely confidential. See the Summary Plan Description for the complete Privacy Statement regarding PHI.

23. How does the Plan save me money?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the health insurance premium is \$400 per month, your monthly income is \$4,000, and you are in the 28-percent federal income tax bracket and the 7.5-percent state tax bracket. Assume also that you expect to have \$2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using the Premium Only Plan and your uninsured medical expenses using the Health FSA Benefit, you will save \$259 per month, or \$3,108 per year. These amounts are computed as follows:



|                                   | <b>Pre-Tax<br/>Medical Plan<br/>\$4,000</b> | <b>No Pre-Tax<br/>Medical Plan<br/>\$4,000</b> |
|-----------------------------------|---|--|
| <b>Salary</b>                     |   |  |
| <b>LESS:</b>                      |   |  |
| Health Insurance Premium          | (400)                                       | 0  |
| Uninsured Medical Expenses        | <u>(200)</u>                                | <u>0</u>                                       |
| Taxable Income                    | 3,400                                       | 4,000  |
| <b>LESS:</b>                      |   |  |
| Federal Income Tax at 28%         | (952)                                       | (1,120)  |
| State Income Tax at 7.5%          | (255)                                       | (300)  |
| Social Security (FICA) at 7.65%   | (260)                                       | (306)  |
| Health Insurance Premium          | 0   | (400)  |
| Uninsured Medical Expenses        | <u>0</u>                                    | <u>(200)</u>                                   |
| Net Take Home Pay                 | 1,933                                       | 1,674  |
| Monthly Tax Savings               | 259   | -----  |
| Annual Tax Savings With This Plan | 3,108                                       | -----  |

You will be provided a form when you first become eligible to participate. This form will notify you of your eligibility for participation in the Plan, upon which you may elect the Premium Only Plan, Health FSA Benefit and/or the DCAP. If you elect the Premium Only Plan, the health insurance premiums you are already making will be converted to a pre-tax basis.

In future years, you will be furnished a new form by the first day of the annual enrollment period and be given the opportunity to confirm or change your existing choices for the coming calendar year.

**24. The Plan sounds too good to be true. Are there any reasons why I shouldn't participate?**

As discussed above, the salary you elect to use to pay for Plan benefits is free from income and FICA taxes. This is a valuable benefit. However, because amounts deferred under the Plan are not counted as wages when determining your Social Security benefit, it is possible that there may be a reduction in your Social Security benefits. If your salary is above the Social Security Taxable Wage Base you probably will not be affected. If your salary is below the Social Security Taxable Wage Base, your Social Security benefits might be reduced. You should consult your own financial or tax advisor to determine the effects of electing to participate in the Plan. If you are using the Plan for reimbursement of insurance premium, it is specifically your responsibility not to request anything that could violate the terms of your insurance policy.

**25. Can I change my election during the Plan Year?**

Generally, you may not change or vary your elections during the Plan Year. However, you may change your elections during the annual enrollment period for the coming Plan Year. The Plan Administrator will advise you when you may elect to change your elections for the upcoming plan year.

There is an important exception to this general rule: You may change or revoke your election at any time during the Plan Year if you have a qualifying change in status (which generally includes a change in your legal marital status or change in the number of dependents). See the qualifying changes in status listed under "Election Changes" in this Summary.

**26. Who holds the funds I have set aside under the Plan?**

The insurance companies providing the benefits under the Plan will receive all amounts withheld from your paycheck for payment of premiums. Amounts contributed under the Health FSA and DCAP benefits will be retained by the Company but earmarked to pay for Health FSA and DCAP Benefits. Separate bookkeeping entries will be maintained to keep track of your Health FSA and DCAP Benefits.

**27. When will my participation in the Plan cease?**

If you elect to participate in the Plan, your participation will continue until you separate from service with the Company or elect to stop making contributions under the Plan. Also, with respect to this Plan, if your employment status changes so that you regularly work less than, the requirements are the same as health insurance, as indicated in CBA or MWC, your participation in the Plan will cease. However, you may be eligible for continuation coverage under this Plan.

**28. What is continuation coverage?**

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Plan Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any other reason. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage.

The Dependent Care Assistance Plan provides a "spend down" period entitling you to claim reimbursement for any qualifying Dependent Care Expenses incurred after termination and before the end of the current Plan Year. Qualifying Dependent Care Assistance expense claims must be filed within 90 days of the end of the Plan Year.

**29. Will I have any administrative costs under the Plan?**

No. The Company will pay the entire cost of administering the Plan.

**30. How long will the Plan remain in effect?**

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

**31. What happens if my claim for benefits is denied?**

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Health FSA are discussed below.

*A. When must I receive a decision on my claim?*

You are entitled to notification of the decision on your claim within 30 days after the Plan Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Plan Administrator will make the decision based on the information that it has.

*B. What information will a notice of denial of a claim contain?*

If your claim is denied, the notice that you receive from the Plan Administrator will include the following information:

- Information that is sufficient to identify the claim involved (including date of service, name of health care provider, claim amount, and a statement that the diagnosis code and its meaning, and the treatment code and its meaning are available upon request);
- The specific reason for the denial including a description of the meaning of any denial code;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

- A description of the Health FSA's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review; and
- If the Plan Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

*C. Do I have the right to appeal a denied claim?*

Yes, you have the right to appeal the Plan Administrator's denial of your claim.

*D. What are the requirements of my appeal?*

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission. You should also include any documentation that you have not already provided to the Administrator.

*E. Is there a deadline for filing my appeal?*

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. Your appeal will be heard and decided by the Committee.

*If you do not file your appeal within this 180-day period, you lose your right to appeal.*

*F. How will my appeal be reviewed?*

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Committee. The Health FSA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Health FSA who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

*G. When will I be notified of the decision on my appeal?*

The Committee must notify you of the decision on your appeal within 60 days after receipt of your request for review.

*H. What information is included in the notice of the denial of my appeal?*

If your appeal is denied, the notice that you receive from the Committee will include the following information:

- Information that is sufficient to identify the claim involved (including date of service, name of health care provider, claim amount, and a statement that the diagnosis code and its meaning, and the treatment code and its meaning are available upon request);
- The specific reason for the denial including a description of the meaning of any denial code;
- The specific reason for the denial upon review;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule,

guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

- A statement of your right to bring a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

Lane Community College  
Schedule A  
QUALIFIED BENEFIT OPTIONS UNDER THE PLAN\*:

NAME OF COVERAGE

- ☐ GROUP HEALTH INSURANCE PLANS
- ☐ INDIVIDUAL HEALTH INSURANCE PLANS
- ☐ GROUP DENTAL COVERAGE
- ☐ VISION CARE INSURANCE
- ☐ GROUP TERM LIFE INSURANCE
- ☐ DISABILITY INCOME-SHORT TERM (A&S)
- ☐ DISABILITY INCOME-LONG TERM (LTD)
- ☐ CANCER INSURANCE
- ☐ ACCIDENTAL DEATH AND DISMEMBERMENT
- ☐ INTENSIVE CARE INSURANCE
- ☐ ACCIDENT INSURANCE
- ☐ HOSPITAL INDEMNITY INSURANCE
- ☐ HEALTH SAVINGS ACCOUNT
- ☐ OTHER: \_\_\_\_\_
- ☐ OTHER: \_\_\_\_\_
- ☐ OTHER: \_\_\_\_\_
- ☐ OTHER: \_\_\_\_\_
- ☐ OTHER: \_\_\_\_\_

\*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.



Lane Community College  
Schedule B  
FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.\*

| Name of Benefit Plans To Be Offered |    | Employee Only | Employee & Child(ren) | Employee & Spouse | Employee & Family | Other: |
|-------------------------------------|----|---------------|-----------------------|-------------------|-------------------|--------|
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | ER | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |
|                                     | EE | \$/%          | \$/%                  | \$/%              | \$/%              | \$/%   |

\* An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to payor otherwise be liable for any deductible, coinsurance, co-payment or other cost sharing amounts related to the applicable medical care coverage option elected by the Participant.

Lane Community College  
Schedule C  
PARTICIPATING AFFILIATED EMPLOYERS  
(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

| Name of Participating Employer | Federal<br>Employer ID<br>Number |
|--------------------------------|----------------------------------|
|                                |                                  |
|                                |                                  |
|                                |                                  |
|                                |                                  |
|                                |                                  |
|                                |                                  |
|                                |                                  |
|                                |                                  |

Lane Community College  
SCHEDULE D  
HEALTH FSA AND DEPENDENT CARE ASSISTANCE PLAN  
EMPLOYEE CONTRIBUTION LIMITATIONS

The Health Flexible Spending Account annual maximum is \$2,500.00, with a monthly maximum equivalent to the total months in the plan divided by the annual maximum.

The Dependent Care FSA annual maximum is \$5,000.00, with a monthly maximum equivalent to the total months in the plan divided by the annual maximum.

Lane Community College  
SCHEDULE E  
HEALTH FSA EXCLUSIONS  
MEDICAL EXPENSES NOT REIMBURSEABLE

The Lane Community College Health FSA Plan document contains the general rules governing what expenses are reimbursable. This Schedule E, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213 (d) and may otherwise be reimbursable under the regulations governing Health FSAs.

This Schedule E does not apply to HSAs. As described in the Plan, terms and conditions of coverage and benefits under the HSA (including eligible medical expenses and exclusions) will be provided by and are set forth in the HSA, not this Plan.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs:

- Dual purpose products, items for general well-being, or items not typically medically necessary (such as Acupuncture, Supplements, Vitamins, Massage Therapy, Dermatology Products, and Weight Loss Programs) are excluded from reimbursement unless accompanied by a letter of medical necessity.

The letter of medical necessity must be from a Physician and must include a diagnosis, duration of treatment, and description of treatment plan.

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

"Cosmetic surgery" means any procedure that is directed at improving the patient's appearance' and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Long-term care services.
- As of January 1, 2011, Over the Counter (OTC) drugs and medicines (e.g. Advil, ibuprofen, cough syrup) are excluded from reimbursement unless accompanied by a prescription from your doctor.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods. Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code § 213(d).
- Any item that is not reimbursable under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.
- The salary expense of a nurse to care for a healthy newborn at home.
- Custodial care.
- Funeral and burial expenses.

Lane Community College  
ELECTION/CHANGE & REVOCATION FORM

**POLESTAR BENEFITS, INC. - EMPLOYEE ENROLLMENT FORM**



SUBMIT FORMS TO: 412 Jefferson Parkway, Suite 202 - Lake Oswego, OR 97035 OR Fax (888) 539-9565 OR Email info@polestarbenefits.com

|   |                  |                       |   |   |                  |   |   |                  |                       |  |  |  |  |
|---|------------------|-----------------------|---|---|------------------|---|---|------------------|-----------------------|--|--|--|--|
| EMPLOYER  |                  | EFFECTIVE DATE        |   | FIRST PAYROLL DATE  |                  | ENROLLMENT TYPE<br><input type="radio"/> Open Enrollment/ New Hire <input type="radio"/> Add / Change Reason: _____ |   |                  |                       |  |  |  |  |
| <b>EMPLOYEE INFORMATION</b>   |                  |                       |   |   |                  |   |   |                  |                       |  |  |  |  |
| LAST NAME   |                  | FIRST NAME            |   | MI  | SSN              | DATE OF HIRE  | DATE OF BIRTH   |                  |                       |  |  |  |  |
| MAILING ADDRESS   |                  | APT                   | CITY  | STATE   | ZIP              | GENDER<br><input type="radio"/> MALE <input type="radio"/> FEMALE   |   |                  |                       |  |  |  |  |
| EMAIL ADDRESS (REQUIRED)  |                  |                       |   | PHONE   |                  | ALT. PHONE  |   |                  |                       |  |  |  |  |
| <b>DEPENDENT INFORMATION</b>  |                  |                       |   |   |                  |   |   |                  |                       |  |  |  |  |
| Special Request: If a Benefit Card is offered, would you like an additional card for your spouse? <input type="radio"/> YES <input type="radio"/> NO  |                  |                       |   |   |                  |   |   |                  |                       |  |  |  |  |
| SPOUSE NAME   |                  | DOB                   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE | CHILD NAME  |                  | DOB   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE |                  |                       |  |  |  |  |
| CHILD NAME  |                  | DOB                   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE | CHILD NAME  |                  | DOB   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE |                  |                       |  |  |  |  |
| CHILD NAME  |                  | DOB                   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE | CHILD NAME  |                  | DOB   | <input type="radio"/> ENROLL<br><input type="radio"/> WAIVE |                  |                       |  |  |  |  |
| <b>SECTION 125 - FLEXIBLE (FSA), DEPENDENT CARE (DCA) SPENDING ACCOUNT &amp; PREMIUM ONLY PLAN</b>  |                  |                       |   | <b>DIRECT DEPOSIT AUTHORIZATION</b>   |                  |   |   |                  |                       |  |  |  |  |
| <b>Flexible Spending Account Election</b><br><table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>PAY PERIOD ELECTION<br/>\$</td> <td># OF PAY PERIODS</td> <td>ANNUAL ELECTION<br/>\$</td> </tr> </table><br><b>Dependent Care Account Election</b><br><table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>PAY PERIOD ELECTION<br/>\$</td> <td># OF PAY PERIODS</td> <td>ANNUAL ELECTION<br/>\$</td> </tr> </table><br><p style="text-align: center; font-weight: bold;">For a Benefit Analysis Worksheet<br/>and a list of eligible expenses, please<br/>refer to page 3 of this packet.</p> |                  |                       |   | PAY PERIOD ELECTION<br>\$   | # OF PAY PERIODS | ANNUAL ELECTION<br>\$   | PAY PERIOD ELECTION<br>\$                                   | # OF PAY PERIODS | ANNUAL ELECTION<br>\$ | <b>ACKNOWLEDGEMENT AND AUTHORIZATION:</b> I hereby request coverage as outlined above under the Polestar Benefits, Inc. plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.***125/FSA and HRA Acknowledgement***The dependents for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I am aware the premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded. Reimbursement account claims must be accompanied by proper documentation (i.e. a reimbursement request and related receipt(s) or Explanation of Benefits) of the out-of-pocket expense and be incurred within the plan year. This agreement cannot be revoked or changed, unless I experience a qualified change in status. <b>WARNING:</b> Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime. |  |  |  |
| PAY PERIOD ELECTION<br>\$   | # OF PAY PERIODS | ANNUAL ELECTION<br>\$ |   |   |                  |   |   |                  |                       |  |  |  |  |
| PAY PERIOD ELECTION<br>\$   | # OF PAY PERIODS | ANNUAL ELECTION<br>\$ |   |   |                  |   |   |                  |                       |  |  |  |  |
| <b>DECLARATION OF PARTICIPATION</b> My Employer's Cafeteria Plan has been explained to me; I have been given the opportunity to participate and have elected not to do so in: <input type="radio"/> Flexible Spending Account <input type="radio"/> Dependent Care Account <input type="radio"/> Premium Only Plan (Opt-Out)  |                  |                       |   | <b>BANK ACCOUNT INFORMATION</b><br><input type="radio"/> CHECKING <input type="radio"/> SAVINGS<br>Routing # _____<br>Account # _____<br><br>I have read and understand the statements above. I hereby authorize Polestar Benefits, Inc. to initiate direct deposits to the bank account listed above. It is my responsibility to notify Polestar Benefits, Inc. of any changes relating to my account. I may cancel the direct deposit option at any time. |                  |   |   |                  |                       |  |  |  |  |
| EMPLOYEE SIGNATURE  |                  |                       |   | DATE  |                  | EMPLOYEE SIGNATURE  |   |                  |                       |  |  |  |  |
|   |                  |                       |   |   |                  | DATE  |   |                  |                       |  |  |  |  |





Lane Community College  
REIMBURSEMENT REQUEST FORM

| POLESTAR BENEFITS, INC. - REQUEST FOR REIMBURSEMENT   |   |                               |   |   |
|---|---|-------------------------------|---|---|
| MEMBER INFORMATION  |   |                               | SEND CLAIMS TO  |   |
| Company Name  |   | Comments                      | Fax   | (888) 539-9565  |
| Employee Name   |   |                               | Email   | claims@polestarbenefits.com                               |
| Employee Phone #  |   |                               | Mailing Address   | 412 Jefferson Parkway, Suite 202<br>Lake Oswego, OR 97035 |
| Employee Email  |   |                               |   |   |
| Please visit <a href="http://www.polestarbenefits.com">www.polestarbenefits.com</a> for additional forms and information.   |   |                               |   |   |
| REIMBURSEMENT REQUESTED   |   |                               |   |   |
| Please list eligible medical, dental, vision services and/or expenses for you and your family that you have not already claimed through Polestar Benefits, Inc. in the appropriate boxes below. Only list the amount of the expense you are eligible for and is not being reimbursed through another Plan, by another Administrator/Carrier.  |   |                               |   |   |
| Services for Reimbursement  | Reimburse from HRA, FSA, Transit or DCA   | Estimated Amount to Reimburse | <p><b>4 Keys to a Quick Reimbursement</b><br/>Please be sure to include:</p> <ul style="list-style-type: none"> <li>● Service Date</li> <li>● Service Provided</li> <li>● Cost of Service</li> <li>● Provider / Member Name</li> </ul>  |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
|   | <input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA | \$                            |   |   |
| IF ANY EXPENSES WERE COVERED BY INSURANCE, PLEASE SEND THE EXPLANATION OF BENEFITS (EOB)  | EXPLANATION OF BENEFITS<br>THIS IS NOT A BILL   |                               |   |   |
| YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.     |   |                               |   |   |
| I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by Polestar Benefits, Inc. may not be claimed on my individual tax return at the end of the year. |   |                               |   |   |
| Employee Signature  |   | Date                          |   |   |
| IF YOUR ADDRESS HAS CHANGED, PLEASE LIST BELOW.   |   |                               |   |   |
| Street/PO Box   |   |                               |   |   |
| City  | State   | Zip                           |   |   |
|   |   |                               | <p>If you have questions about filing claims, please contact us!</p> <p><b>Toll Free: (855) 222-3358</b></p> <p><b>Email: <a href="mailto:claims@polestarbenefits.com">claims@polestarbenefits.com</a></b></p>                       |   |

## HOW TO ADOPT THE HEALTH FSA GRACE PERIOD

The IRS allows Employers to modify the Health FSA "use it or lose it" rule by adopting a grace period of up to 2 1/2 months following the end of the current Plan Year. If the Grace Period is adopted, participants with a balance remaining at the end of the Plan Year will be able to use it for qualifying expenses incurred during that Grace Period.

An Employer is not required to adopt the grace period, but Employers who wish to adopt the Grace Period for their current Plan Year must amend their Plan before the end of that Plan Year.

The template on the following page can be used to Amend your Plan to adopt the Grace Period for the current Plan Year.

Should you choose to amend your Plan to adopt the Grace Period:

1. Complete the "Amendment Adopting Grace Period" and place it in Section 1 of your Plan Document, in front of the Resolution to Adopt the Plan and any previous Amendments.
2. Complete the Summary of Material Modifications (SMM); distribute a copy to each eligible Employee; place a copy at the end of your Plan Document and at the end of your Summary Plan Description. You must notify Plan participants of the extended Grace Period prior to the end of the Plan Year.

Lane Community College  
AMENDMENT ADDING GRACE PERIOD  
IRC SECTION 125 CAFETERIA PLAN  
As Permitted by IRS Notice 2005-42

WHEREAS, Lane Community College has determined that it would be in the best interests of its employees to adopt the Grace Period for their "Section 125 Health Flexible Spending Account" as permitted by IRS Notice 2005-42, so-called; be it known that a vote was taken, and all were in favor to amend said Plan herein, to be effective for the current Plan Year.

RESOLVED, that Lane Community College amend its so-called "Section 125 Health FSA Plan", all in accordance with the specifications annexed hereto; and, be it known that the amended "Health FSA Plan" Document was executed 01/01/2013. These amendments shall apply notwithstanding any other statements in the Plan, the summary plan description (SPD), or any other documents for the current Plan Year.

RESOLVED FURTHER, that Lane Community College undertake all actions necessary to implement and administer said amendment.

The undersigned hereby certifies that he/she is qualified by Lane Community College company duly formed pursuant to the laws of the State of Oregon, and that the foregoing is a true record of an amendment duly adopted, and that said amendment is now in full force and effect without modification or rescission for the current Plan Year.

IN WITNESS WHEREOF, I have executed my name for the above named Company on 01/01/2013.

A True Record

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Authorized Signer

Lane Community College  
HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) GRACE PERIOD  
SUMMARY OF MATERIAL MODIFICATIONS  
PURPOSE

The Health FSA (the "Plan"), adopted by Lane Community College on 01/01/2013 is herein amended effective 01/01/2013 adopt the Grace Period for the current Plan Year.

Grace Period will begin on the last day of the plan year and end 75 thereafter. Grace Period will apply to unused amounts remaining in your Health FSA Account on 12/31/2013.

A. Plan Amendments

1. Grace Period for Health FSA Component:

Amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the period that begins immediately following the close of that Plan Year and ends on a day that is *no more than* two months plus 15 days following the close of that Plan Year (the Grace Period) under the following conditions:

*(a) Applicability.*

In order for an individual to be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates (Prior Plan Year Health FSA Amounts), he or she must be either (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

*(b) No Cash-Out or Conversion.*

Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

*(c) Reimbursement of Grace Period Expenses.*

Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Health FSA Component will be reimbursed and charged first against any available Prior Plan Year Health FSA Amounts and then against any amounts that are available to reimburse expenses that are incurred during the current Plan Year. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise re-characterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

*(d) Run-Out Period and Forfeitures.*

Claims for reimbursement of Medical Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than 90 days after end of Grace Period following the close of the Plan Year in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends. The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in Section 6.6 of the Plan.

*(e) Debit Cards (if applicable).*

Claims for reimbursement of Medical Care Expenses incurred during the Grace Period may require submission of a manual claim form in order to use available Prior Plan Year Health FSA Amounts. If a Debit Card is provided to access your Health FSA funds, verify with your Plan Administrator whether you may use your Debit Card to access amounts available from Prior Plan Year Health FSA during the Grace Period. Caution Regarding Impact of Grace Period on Eligibility to Contribute to a Health Savings Account (HSA). Under IRS rules regarding the grace period, if you have an election for Health FSA coverage that is in effect on the last day of a Plan Year, you (and your spouse, if you are married) cannot contribute to an HSA during the first 90 days following the close of that Plan Year, unless the balance in your Health FSA Account is \$0 as of the last day of that Plan Year. For this purpose, your Health FSA



Account balance is determined on a cash basis, that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

Please attach this document to your SPD for future reference.

If you have questions, please contact the Plan Administrator.

**Plan Administrator Information**

Polestar Benefits, Inc.

412 Jefferson Parkway, Ste. 202

Lake Oswego, OR 97035

Phone: 855-222-3358

**General Information**

- Name: Lane Community College Flexible Benefits Plan (511)
- Plan Number: 511
- Effective Date: 01/01/2013
- Plan Year: 01/01/2013 to 12/31/2013