



Flexible Spending Program

Summary Plan Description

January 2005

This summary plan description provides only a general description of benefits available under the DePaul University Flexible Spending Account Program; it is not a legal document nor is it a contract of employment. It is based on legal documents, insurance certificates, and contracts that provide complete plan details. While every practicable attempt has been made to ensure accuracy and consistency, in the event of any conflict between this summary plan description and official plan documents, the plan documents shall govern. Copies of the plan documents are available upon request at the Benefits Office during regular business hours.

This summary plan description is provided in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). DePaul University reserves the right to amend or terminate any of the plans described in this summary plan description at any time and with respect to any class of participants, subject to the limitations of University policies and applicable law. The University also reserves the right to change the premiums required for plan participation at any time.



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FLEXIBLE SPENDING PROGRAM

DePaul University offers its employees a Flexible Spending Account Plan, which includes:

- ◆ the Health Care Flexible Spending Account (FSA), and
- ◆ the Dependent Care Flexible Spending Account (FSA).

The plan provides you with a convenient way to pay for your eligible health care expenses and dependent care expenses on a pre-tax basis through payroll deduction. You decide the total amount to contribute. These amounts will be deducted in equal amounts from 24 of your 26 paychecks throughout the year *before* taxes are calculated. As a result, you pay less in taxes and may increase your take-home pay.

You should plan your annual FSA contributions carefully, because Internal Revenue Service (IRS) regulations stipulate that you forfeit any money left in your accounts after your expenses for the year are paid.

ELIGIBILITY

Full-Time Employee Classification

You are eligible for coverage under the DePaul University Flexible Spending Program if all of the following apply:

- ◆ you are in an active faculty or staff member position classified as full-time
- ◆ you are not covered by a collective bargaining agreement.
- ◆ you are not in a position classified as a student worker
- ◆ you are not a member of the Midwest Province of the Congregation of the Mission

You are considered a full-time (except temporary, contact or student) employee if you are in:

- ◆ a faculty position, under a contract or letter of appointment issued by the Office of the Executive Vice President for Academic Affairs.
- ◆ a staff or security position classified as full-time and regularly scheduled to work at least 1,820 hours per year.

Independent contractors are not employees of the University and are not eligible for group benefits. Local and third country nationals (non-resident aliens) are not eligible for benefits.



Part-Time Employee Classification

Part-time employees are eligible to participate in the Flexible Spending Program if they they meet the following criteria:

Faculty: Benefits eligibility is reviewed at the end of each academic year to determine eligibility for the following academic year. In order to be eligible in the following academic year:

- ◆ You must have at least one year of continuous service (determined by academic year, September through June) and you must have taught at least six 4-credit hour courses (or the equivalent) in that academic year (or seven courses including the summer sessions); and
- ◆ You must be committed to teach at least six 4-credit hour courses (or the equivalent) in that academic year (or seven courses including the summer sessions) for the upcoming academic year (the year for which eligibility is being determined).

Equivalences will be determined by the Deans and approved by the Executive Vice President for Academic Affairs.

Staff: Benefits eligibility is reviewed at the end of each calendar year to determine eligibility for the following calendar year. In order to be eligible in the following calendar year:

- ◆ You must have worked one complete calendar year (January through December) and you must have completed 1,000 hours in that calendar year based on payroll records; and
- ◆ Your department manager must certify that you are projected to work at least 1,000 hours in the following calendar year (the year for which eligibility is being determined)

In determining the 1,000 hours under under the first requirement, all part-time positions held by an incumbent will be considered.

Instructional Associate Classification

Instructional Associates are eligible for coverage under the Flexible Spending Program if all of the following apply:

- ◆ You are in a part-time faculty position classified as Instructional Associate
- ◆ The Instructional Associate classification is a grandfathered group and is not available for new positions

Job Share Employee Classification

You are eligible to participate in the Flexible Spending Program on the date you are in a position classified as a job share position as defined by the job share policy.



Vincentian House Employee Classification

If you are in a Vincentian House position, you are eligible to participate in the Flexible Spending Program.

Eligible Dependents

If you are eligible for the Flexible Spending Program, you may cover your eligible dependents. They include:

- ◆ your spouse
- ◆ your (or your spouse's) unmarried children under age 23 including adopted children and children placed for adoption.
- ◆ children under age 23 for whom you are legal guardian

All children must be eligible to be federal income tax dependents. This plan does not provide coverage for foster children or grandchildren unless you have obtained legal guardianship.

If you have an unmarried child with a mental or physical disability who is eligible to be a federal income tax dependent, coverage for that child may continue after coverage would normally end, as long as the disability began before that dependent reached age 23. You will need to give proof of the disability to the Plan Administrator from time to time, or this continued coverage will end.

If you gain an eligible dependent through a change in family status or coverage change, you may cover that dependent by applying to the Benefits Office within 31 days after you have legally acquired the dependent. Coverage will begin as of the date you acquired the dependent.

Eligible Dependents Under Dependent Care FSA

Dependents eligible to participate in a dependent care flexible spending account generally include your children and step-children under age 13 or your dependents of any age who are incapable of caring for themselves due to mental or physical impairment or handicap.

Eligible dependents include:

- your (or your spouse's) unmarried children under age 13 including adopted children and children placed for adoption, if they are eligible to be a federal income tax dependent
- children under age 13 for whom you are legal guardian and are eligible to be a federal income tax dependent
- children, spouses and other tax dependents (within the meaning of Section 152 of the Internal Revenue Code) of any age who are physically or mentally incapable of caring for themselves.

If you gain a dependent who meets the eligibility criteria listed above through a change in family status or coverage change, you may cover that dependent by applying to the Benefits Office within 31 days after you have legally acquired the dependent. Coverage will begin as of the date you acquired the dependent.



Change in Family Status

You may be permitted to revoke an existing election and make a new election for the remaining portion of the plan year if the revocation and new election are consistent with a change in family status or coverage.

The Benefits Office will review the situation to determine if a family status or coverage change has occurred. If approved, the change will be effective on the date of the change. Any change in your deductions (if applicable) will be effective the first pay period of the change.

ENROLLMENT

You can enroll when you first become eligible and each year during the open enrollment period. The FSA open enrollment period is held annually in the Fall. *If you choose to continue contributing to the FSA for the new year, you must participate in open enrollment.* Coverage will be effective January 1 of the following year.

Federal law requires that you make a new election for the flexible spending accounts *each* year. Therefore, you are required to re-enroll each year during open enrollment. Also, you cannot change your election during the plan year for which it is effective, unless you have a family status change or coverage change.

When Coverage Begins

Your first contribution will be deducted from your paycheck following the date you begin to participate in the plan.

Contributions

The Health Care FSA and Dependent Care are separate accounts. Contributions to one FSA cannot be used to pay for eligible expenses for the other FSA. When you enroll, and during the open enrollment period each year, you decide how much money you want to contribute for the next calendar year. You should base your health care and dependent care contributions on what out-of-pocket expenses you expect to pay for the coming year.

Deductions are taken on a pre-tax basis from 24 of the 26 annual pay checks.

Tax Withholding

Withholding for federal income taxes, state income taxes and FICA (Social Security taxes) will be based on the reduced salary after contributions to a health care and/or dependent care flexible spending account.

The reduction in tax withholding may result in an increase in your take-home pay. Since your earnings reported to Social Security are reduced, your Social Security benefits may also be slightly reduced.



The Importance of Budgeting Carefully

Before you make your annual health care or dependent care election, carefully review and estimate what you anticipate to pay out-of-pocket for your health care costs and dependent care expenses during the plan year.

According to IRS regulations, you will forfeit any money left in your accounts after expenses for the year are paid. You may not carry over your account balance from one year and apply it toward your next year's health care or dependent care expenses. Keep in mind that once you've made your annual contribution elections, no changes can be made for that plan year, unless you have a change in family status or coverage change as specifically defined by the IRS.

The Bottom Line — An Example

The following example illustrates the effect of participating in the Flexible Spending Account Plan for an employee earning \$30,000. We'll assume the employee has a spouse, two dependent children and files a joint tax return.

Tax Savings Example		
Here is an example that shows your tax savings if you pay your out-of-pocket health care expenses with before-tax dollars.		
	With Reimbursement Account	Without Reimbursement Account
Employee's annual gross pay	\$ 30,000	\$ 30,000
Health Care Reimbursement Account election	1,000	-0-
Net taxable pay	29,000	30,000
Estimated Federal, State, and Social Security Tax Withholding*	7,439	7695
After-tax Income	21,561	22,305
Out-of-pocket health care expenses	-0-	1,000
Net take-home pay	21,561	21,305
Annual tax savings	\$ 256.00	\$-0-
*This example assumes that you are in the 15% federal income tax bracket, pay 3% state income tax, and have 7.65% Social Security/Medicare (FICA) deducted from your paycheck.		



PLAN SPECIFICS

The Flexible Spending Account Program is designed to help you save money by paying for many health care and dependent care expenses on a pre-tax basis. You can elect one or both of the following options:

- ◆ **Health Care Flexible Spending Account** — Direct a portion of your salary to your Health Care FSA and pay for eligible health care expenses on a pre-tax basis.
- ◆ **Dependent Care Flexible Spending Account** — Direct a portion of your salary to your Dependent Care FSA and pay for eligible dependent care expenses on a pre-tax basis.

HEALTH CARE FSA

You may contribute from \$250 to \$5,000 to your Health Care FSA each year. If you contribute to the Health Care FSA, your contributions will be deducted over 24 pay periods. Then the amount you contribute will be reimbursed to you for eligible health care expenses you and your dependents incur during the plan year.

You can be reimbursed from your FSA only for eligible health care expenses that are not reimbursed from DePaul's Medical, Dental or Vision Plans or another health insurance policy.

Eligible Expenses

Health care expenses eligible for reimbursement under the plan are based on IRS guidelines. They include, but are not limited to, the following (so long as the expense was not reimbursed through another source as previously discussed):

- ◆ deductibles and copayments
- ◆ routine physical exams
- ◆ school physicals
- ◆ well-baby care
- ◆ immunizations
- ◆ lab fees
- ◆ emergency room care
- ◆ crutches, wheelchairs
- ◆ ambulance services
- ◆ surgery
- ◆ hospital bills
- ◆ physician bills
- ◆ private nursing care
- ◆ psychological or psychiatric care



- ◆ chiropractic care
- ◆ physical therapy
- ◆ artificial limbs and prosthetic devices
- ◆ prescription drugs
- ◆ dental, vision, hearing care
- ◆ certain over-the-counter drugs

Reimbursement for Certain Over-the- Counter Medications

The IRS and Treasury Department recently announced that participants of a Health Care Flexible Spending Account (FSA) can submit the cost of certain over-the-counter medicines for reimbursement through their FSA.

These items must be for the purpose of providing medical care. Medical care is defined as diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. The IRS specifically addressed antacid, allergy medicine, pain reliever, and cold medicine as eligible expenses. Listed below are categories of medicines that will be eligible effective January 1, 2004:

Allergy Medicines	Cold Medications	Anti-itch
Antihistamines Decongestants Nasal Sprays Sinus Medication	Cough Drops Cough Syrups Decongestants Flu and cold medications Sore throat sprays Vapor Rubs	Antihistamines Athletes foot creams, powders
Digestive Tract Relief	Pain Relievers	Miscellaneous
Antacids Anti-diarrhea medications Anti-nausea medications Heartburn medications	Acetaminophen (Tylenol) Ibuprofen (Motrin) Naproxen Sodium (Aleve) Disinfecting creams	Cold sore remedies Eye Drops Lice Treatments Nicotine patch/gum Anti-inflammatory drugs Wart removers Yeast infection treatments

Vitamins, supplements and herbal remedies are typically used to improve general health. Therefore, these items would still not be eligible to be submitted for reimbursement through a flexible spending account.

Valid documentation must be submitted in order for the expense to be considered for reimbursement. The receipt must show:



- The name of the pharmacy
- The name of the item
- The cost of the item
- The date it was purchased

If you need further clarification on what expenses are allowable, please contact the flexible spending account administrator, Administrative Management Group (AMG) at 800-356-FLEX (800-356-3539).

As required by the IRS, you must incur an expense during the plan year to be eligible for reimbursement. "Incurred" refers to the date you received services. **Claims will be reimbursed based on the date you received services, regardless of when you are billed or when you pay the expense.**

Ineligible Expenses

Health care expenses that are not eligible for reimbursement under the plan include, but are not limited to the following:

- ◆ expenses that are reimbursable under any other health plan
- ◆ elective cosmetic surgery or services (e.g., teeth bleaching)
- ◆ cosmetic medication (e.g., Rogaine)
- ◆ insurance premiums (e.g., eye club fees, individual policy premiums, auto insurance premiums, health insurance premiums)
- ◆ fitness club dues

Please refer to *IRS Publication 502, Medical and Dental Expenses*, for a listing of expenses that may be eligible for reimbursement. The publication is available from your local IRS office. Please note not all expenses listed in Publication 502 are eligible for reimbursement through a Health FSA. To determine if a particular expense is eligible for reimbursement, you may call the plan administrator, Administrative Management Group (AMG) at 800-356-3539. Expenses reimbursed through the Health FSA are not deductible on your federal income tax return. To determine whether participation in the Health FSA or the tax deduction for medical expenses would be more beneficial, please consult a qualified tax advisor



DEPENDENT CARE FSA

You may contribute a minimum of \$500 to a maximum \$5,000 to the Dependent Care FSA. The IRS limits the amount you may direct to a Dependent Care FSA each year to the lesser of the following:

Limits on Your Dependent Care FSA Contributions	
If This Is Your Situation...	The Most You Can Contribute to Your Dependent Care FSA Is...
You are: single filing as head of household or married and filing jointly	\$5,000
You are married and your spouse is also contributing to an FSA or You and your spouse file separate tax returns	\$2,500
Your spouse is a full-time college student or Your spouse is mentally or physically handicapped	Up to \$200 for one child or \$400 for two or more children

Contributions you make to the Dependent Care FSA will be deducted from your paycheck in equal amounts. You will then be reimbursed when you incur eligible dependent care expenses during the plan year.

The amount of reimbursement payable to you at any particular time cannot exceed the balance in your Dependent Care FSA.

Eligible Expenses

To be eligible for reimbursement, dependent care must be necessary to allow you (and your spouse) to work. Care must be provided by someone other than a dependent for whom you claim an exemption on your federal income tax return.



Eligible expenses include, but are not limited to, the following:

- day-care center (centers that care for more than six children must be state-licensed)
- babysitters or nurses needed to care for a dependent so that you can work
- services provided inside or outside your home for the care of a dependent
- after-school care expenses
- nursery school expenses
- nursery school expenses

The Federal Tax Credit and the Dependent Care Spending Account

Eligible expenses under the Dependent Care Spending Account are the same expenses that would allow you a dependent care tax credit on your federal income tax return. You will need to decide which one would be more advantageous based on your personal situation.

You cannot use the Dependent Care Spending Account and the federal dependent care tax credit for the same expenses

Should you use the Tax Credit or participate in a DCAP?

- Using the Dependent Care Spending Account reduces your taxable income but may in a reduction of future Social Security benefits.
- The federal dependent care tax credit reduces your federal income tax by a percentage of your qualifying dependent care expenses. Although that percentage will vary according to your family income, the maximum expense that can be used for the credit is \$3,000 for one dependent and \$6,000 for two or more dependents. The tax credit is figured on a sliding scale, which ranges from 20% to 35%, depending on the parent's income. The adjusted gross income (AGI) level at which the credit begins to phase out is \$15,000.
- Currently, the threshold where the dependent care credit and dependent care FSA provide about the same percentage of tax savings is around \$40,000 of Adjusted Gross Income (AGI). This means those with annual income of more than 40,000 and who are in the 25% tax bracket generally have a greater tax savings using the dependent care FSA.
- Under these limits, a single parent filing as head of household with one child and \$3,000 of dependent care expenses may have better tax savings using the tax credit. However, this same individual having \$5,000 in dependent care expenses may find the employer's dependent care FSA more advantageous.

To determine whether the Dependent Care Spending Account or the federal dependent care tax credit would be more advantageous to you, please consult a qualified tax advisor



CLAIM PROCEDURES

After you pay an eligible health care or dependent care expense, file the appropriate Health Care FSA or Dependent Care FSA claim form with your original receipts for payment with the claims administrator. The Health Care FSA and the Dependent Care FSA are separate accounts. You can be reimbursed only for health care expenses from your health care FSA and only for dependent care expenses from your Dependent Care FSA. Forms are available on-line or at the Benefits Office.

Health Care FSA

To request reimbursement from the Health Care FSA, you should submit a claim form with the original receipts to the claims administrator no later than March 31 following the end of the plan year in which such health care expense was incurred.

Your request for reimbursement must include:

- the amount of the health care expense for which reimbursement is requested
- the purpose of the health care expense
- the name of the person who incurred the health care expense, and, if the person is not you, the person's relationship to you and a statement that the person is your dependent
- the date the health care expense was incurred
- the name of the person, organization or other provider who was paid for the health care
- a statement that you have not been reimbursed for the health care expense by insurance or otherwise and have not been allowed a prior year deduction for such health care expense under Section 213 of the Internal Revenue Code
- a written statement from an independent third party attesting to the nature and amount of the health care expense

If the expenses are covered under any group health insurance plan, you must first submit a claim to the insurance plan before submitting the expenses to the claims administrator for reimbursement from your FSA. The Explanation of Benefits Form also known as the Determination of Benefits, will supply the majority of information necessary for the plan administrator to process your claim.

When you submit a claim for reimbursement from your Health Care FSA, you will be reimbursed up to the total of your eligible expense, even though your account balance is not sufficient when the claim is submitted. Remaining contributions during the year will be used to offset the amount reimbursed. However, your claim cannot exceed your authorized annual contribution amount. Your total authorized reimbursement will be reduced, of course, by any prior reimbursement(s) you have received.



Dependent Care FSA

With the Dependent Care FSA, you should submit a claim form to the claims administrator no later than March 31 of the following calendar year in which the expense was incurred. Each request for reimbursement must include the following:

The nature of the services performed.

The name and age of the dependent for whom services were performed.

The relationship, if any, of the person who performed the services for your child.

A statement by an independent third party about what services were performed, where and when and their cost.

A statement that any services performed outside the home were for a dependent who spends at least eight hours a day in your home.

A statement that any services in a day-care center were in a qualifying facility, accompanied by any information necessary to establish that fact such as a tax identification number.

For providers other than a qualifying day care center, the provider's name and Social Security number.

If you are married:

- a statement your spouse's salary or wages, if employed, exceeds aggregate eligible expenses for the year, or
- if your spouse is not employed, a statement that your spouse is incapacitated or is a full-time student attending an educational institution.

Reimbursements for Health Care FSA and Dependent Care FSA expenses are direct deposited into your checking or savings account semimonthly. Checks normally will be issued on the 15th day and the 30th day of the month. In the event the 15th or 30th falls on a holiday, or a weekend, you will receive your reimbursement on the next business day. (

To help you keep track of your Health Care FSA and Dependent Care FSA balances, the claims administrator will issue statements to participants periodically. Claims reimbursements must be for at least \$25 unless the Plan Year has closed, in which case a final claim for reimbursement of expenses totaling less than \$25 may be made

Claims Review Process

After you submit your claim for reimbursement, the claim administrator will decide if the claim is eligible for reimbursement within a reasonable time. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Administrator has the right to require such other evidence as it deems



necessary in order to decide your claim. If the Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If Your Claim Is Denied

If your claim is denied in whole or in part, you will be notified in writing by the Administrator within 30 days of the date the Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete.)

The Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

Notification of a denied claim will set out:

- ◆ a specific reason or reasons for the denial;
- ◆ the specific Plan provision on which the denial is based;
- ◆ a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- ◆ appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appeals under the Plan.

If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Named Fiduciary. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court.

Your written appeal should state the reasons that you believe your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim.

You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.



Decision on Review

Your appeal will be reviewed and decided by the Named Fiduciary or other entity designated in the Plan in a reasonable time not later than 60 days after the Named Fiduciary receives your request for review. The Named Fiduciary may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA.

WHEN ON A LEAVE OF ABSENCE

When you are on an approved leave of absence you may be eligible to continue your participation in the flexible spending program. Please contact the Benefits Office for more information.

If you are participating in the plan and take an unpaid leave of absence during the year, you have the following options:

Before your leave of absence begins, you may arrange to have your contributions for the period of the leave of absence deducted from your last paycheck(s) on a pre-tax basis. This option allows you to continue to participate in the plan.

You may elect to continue to participate in the plan during a leave of absence by contributing your Health Care FSA contributions for the period of the leave of absence on an *after-tax* basis.

You may revoke your election to participate in the plan. Under this option, only expenses incurred before your leave of absence are eligible for reimbursement. You will not be able to participate in the plan again until you return from your leave of absence.

You may not continue your Dependent Care FSA while on a leave of absence. Pursuant to IRS regulations, in order to participate in a Dependent Care Spending Account you must be employed or actively looking for work.



WHEN YOU RETIRE

If you retire, you and your qualified beneficiaries may continue participation in the Health Care FSA on an *after-tax* basis through the end of the calendar year in which you retire.

WHEN COVERAGE ENDS

Your participation in the plan ends on the earlier of the following dates:

- the date you become ineligible, or
- the last day of the calendar year, if you elect not to re-enroll for the next plan year.

If your employment with the University ends but you are rehired during the same plan year, you will not be able to participate in the plan until the beginning of the next plan year. You will be able to make a new election for the next plan year during the next annual open enrollment period.

If you end employment but are rehired in a subsequent plan year, you will be able to participate in the plan on the first day after you meet the eligibility requirements.

COBRA CONTINUATION OF COVERAGE FOR A HEALTH CARE FSA

A health care flexible spending account at Depaul University is a group health coverage subject to the federal health benefits continuation law — referred to as “COBRA.” COBRA continuation coverage, created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you to elect a temporary extension of your Health Care FSA. DePaul University is the plan administrator and is responsible for administering COBRA continuation coverage. This section of the SPD is meant to inform you and your family of your rights and obligations under COBRA.

Rights to Elect Continued Coverage

Generally, you, your spouse and your dependent children can elect to continue coverage in the Medical Program, Dental Plan and Vision Plan. You may elect to continue coverage in the Health Care Flexible Spending Account (FSA). Coverage may continue for up to 18 months if coverage would otherwise end because of one of the following reasons, called “qualifying events”:

- ◆ voluntary termination of employment,
- ◆ involuntary termination of employment for reasons other than gross misconduct, or
- ◆ change of employment status due to reduction in hours.



Your spouse and any dependent can elect to continue coverage for up to 36 months if coverage would otherwise end because any of the following qualifying events occur:

- ◆ death of the employee,
- ◆ divorce,
- ◆ legal separation, or
- ◆ employee entitlement to Medicare benefits.

Your dependent child can elect to continue benefits for up to 36 months from the date the child reaches age 23 and no longer qualifies as a covered dependent under the plan.

In some cases, when a qualifying event permits your spouse and your dependent children to elect continued coverage for 18 months, a second qualifying event occurs during that 18-month period. Your spouse and children may then elect to continue coverage for an additional 18-month period; however, in no case may coverage continue longer than 36 months after the original qualifying event.

For example, suppose you stop working for DePaul and you, your spouse and your dependent children elect continued coverage. Coverage would normally continue for 18 months. However, during that 18-month period, you and your spouse divorce. Your spouse and children may elect continued coverage for an additional 18-month period, for a total period of 36 months from the time your employment with DePaul ended.

Notices

The university will notify you if you become entitled to elect to continue your coverage. However, you and your family must notify the Benefits Office at DePaul in writing within 60 days in the event of:

(1) divorce or legal separation; (2) when a child no longer qualifies as a covered dependent under the plan; or (3) a subsequent qualifying event. Upon receipt of the notice, the Benefits Office will send the qualifying beneficiary a COBRA election package to complete and return during the 60-day election period (see below).

Type of Coverage

If you elect to continue medical, dental, vision or Health Care FSA coverage under the plan you are currently enrolled in, your benefits will be the same as for active employees. You will not be required to give evidence of good health in order to continue coverage.

Election Period

To elect COBRA, a qualified beneficiary must return a completed election form to the Benefits Office so that it is received no later than 60 days from (1) the date coverage would otherwise be lost, or (2) the date indicated on the COBRA notice. If the qualified beneficiary timely elects COBRA coverage, coverage will be retroactive to the date coverage would otherwise have been lost. One qualified beneficiary may elect COBRA coverage on behalf of any other qualified



beneficiary in the same family. Each qualified beneficiary may, however, independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child. If a qualified beneficiary waives COBRA coverage, the waiver may be revoked before the end of the COBRA election period. In this case, COBRA coverage will only commence on the date the waiver is revoked.

Cost of Continued Coverage

You pay the full cost of your continued coverage.

If you decide to continue coverage after the date your coverage would otherwise terminate, you have 45 days from the date of your election to pay for your retroactive coverage.

At that time, you will have to pay for the following:

- ◆ coverage during the 60-day election period, and
- ◆ coverage during the 45-day payment period following that date.

After that, regular monthly payments for coverage will be due on or before the first of the month.

Disabled Beneficiaries

If Social Security determines you or a covered dependent is disabled within 60 days of your initial COBRA qualifying event, you can request an extension in the maximum coverage period for you and your covered dependents from 18 to 29 months. To obtain this extended coverage, you must notify the Benefits Office in writing of Social Security's disability determination within 60 days of the determination and before the end of the 18-month qualifying period.

If you qualify for this extended coverage, you must pay 100% of the full cost of your continuation coverage.

If you have qualified for this extended coverage, you must also notify the Benefits Office within 30 days of a final determination made by Social Security that you or your covered dependent is no longer disabled.

When Continued Coverage Ends

Continued coverage for any covered person will be terminated on the earliest of the following dates:

- ◆ the date the maximum time period (18, 29 or 36 months) is reached,
- ◆ the last date coverage was paid for, if subsequent required payments are not timely received,
- ◆ the date the person becomes covered by another group plan (but only if that plan does not limit or exclude coverage for any preexisting condition of the person),
- ◆ the date the person becomes entitled to Medicare, or
- ◆ the date DePaul no longer provides the benefits for any of its employees.



Once continued coverage is terminated, it cannot be reinstated.

If you have any questions about continuation coverage, please contact the Benefits office at 312-362-8232. or you may contact the nearest regional or district office of the US Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of Regional and District EBSA Offices are available at EBSA's web site, www.dol.gov/ebsa.

COVERAGE AFTER YOUR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PARTICIPATION ENDS

Dependent Care Spending Account coverage cannot be continued through COBRA. You cannot make any further contributions to the plan after your final paycheck. However, you may continue to submit eligible expenses that were incurred prior to end of your last pay period of participation. In addition, you can submit expenses you may incur during the remainder of the calendar year in which your participation in the dependent care FSA ended, until you no longer have a balance in your Dependent Care Spending Account. Expenses incurred after the end of the calendar year in which your participation ended are not eligible for reimbursement.

To determine your available balance, please contact the flexible spending account administrator, Administrative Management Group (AMG) at 800-356-FLEX (800-356-3539). Your dependent care expenses must be submitted by March 31 following the end of the year in which your employment ends.



ERISA RIGHTS

As a participant in the DePaul Medical Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- ◆ Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- ◆ Obtain upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may impose a reasonable charge for the copies.
- ◆ Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

If you have creditable coverage from another plan, you will receive a certificate of coverage that helps to reduce or eliminate exclusionary periods of coverage under your new group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group medical plan or medical insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (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 your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.



Enforce Your Rights

If your claim for a (pension, 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 or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration



ERISA PLAN INFORMATION

Name	Flexible Spending Program
Plan Number	501
Type of Plan	Flexible Spending
Type of Administration	Claims Administration
Effective Date	January 1, 2004
Plan Sponsor	DePaul University 1 E. Jackson Chicago, Illinois 60604
Employer ID Number (EIN)	36-2167048
Plan Administrator	DePaul University 1 E. Jackson Chicago, Illinois 60604
Claims Administrator	Administrative Management Group 3800 Wilke Road Arlington Heights, IL 60004
Agent for Service of Legal Process	DePaul University 1 E. Jackson Chicago, Illinois 60604
If Legal Process Involves Claims for Benefits Under the Group Policy, Additional Notification of Legal Process Must be Sent to	Administrative Management Group 3800 Wilke Road Arlington Heights, IL 60004
Plan Year	The 12-month period ending December 31 ST Records of the Plan are kept on a calendar year basis.
Sources of Contributions	Employee pre-tax salary contributions
Funding Method	The Flexible Spending Plan is paid from the general assets of DePaul University