

**THE UNIVERSITY OF MISSISSIPPI
CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION**

(REVISED August 2005)

**UNIVERSITY OF MISSISSIPPI CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION**

University of Mississippi (the "Employer") is pleased to sponsor an employee benefit program known as a "Cafeteria Plan" (the "Plan") for all employees. It is so-called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary reduction arrangement instead of a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your salary reduction.

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

PART I

General Information about the Cafeteria Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction, to choose one or more of the Benefit Package Options offered through the Plan, and enable them to pay for the selected coverage(s) with pre-tax dollars.

Q-2. What benefits can I purchase on a pretax basis through the Plan?

You will be able to choose to participate in the Plan's pre-tax program options by filling out any required enrollment form(s) for the component Benefit Package Option. The various benefit options available will be described to you in information materials distributed prior to each enrollment period. The Plan currently enables you to purchase the following benefits on a pre-tax basis.

- Medical Care Expense Reimbursement Account
- Dependent Care Expense Reimbursement Account
- Group Health Insurance
- Dental Insurance
- Accidental Death and Dismemberment
- Cancer/Dreaded Disease and Intensive Care

For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each of the above programs. Ask your Human Resource Department for copies.

Q-3. Who can participate in the Plan?

Each Employee who is eligible for coverage or participation under any of the Benefit Package Options shall be eligible to participate in this Plan at the time coverage commences under the component Benefit Package Options. Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until he or she: i) elects not to participate in accordance with Q-7; or ii) is no longer employed by the Employer, or Continuation Coverage (as described below) is no longer in effect.

Q-4. What tax advantages are available through the Plan?

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

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

Q-5. How do I become a participant?

You become a Participant by signing an individual Cafeteria Election Form on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You will be provided a Cafeteria Election Form when you first become eligible to participate. You must complete the form and turn it in to the Human Resources Department within the time period specified

by the Plan Administrator. If you are eligible on the initial Effective Date of the Plan, you will be able to enter the Plan during the Initial Enrollment Period and shall become a Participant on the Effective Date. Otherwise, you will be able to enter the Plan on the effective date of your coverage under the component Benefit Package Options.

In future years, a new Cafeteria Election Form will be made available to you by the first day of the Annual Enrollment Period, and you will be given the opportunity to confirm or change your choices made for the previous 12-month period for the coming 12 months beginning on the first day of the next Plan Year. This twelve month period is called the "Plan Year". A Participant who fails to complete, sign and file a Cafeteria Election Form as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and (except for a Change in Status) will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the medical and dependent care expense reimbursement plans must be made by submitting a salary reduction agreement prior to the beginning of each plan year - no deemed elections shall occur with respect to such benefits.

Q-6. What are the enrollment periods for entering the Plan?

The Enrollment Period will generally begin at least 30 days before the Anniversary Date (January 1st) and end on a date specified by the Human Resources Department.

Q-7. Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Pre-Tax Premium payment option or vary the Pre-Tax Premium you have selected, during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections for Pre-Tax Premiums only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election for Pre-Tax Premiums during the Plan Year if you file a written request for change with the Plan Administrator within thirty (30) days of any of the following events:

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

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse)
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent)
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, 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 part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit.
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student)
- a change in your, your Spouse's or your Dependent's place of residence

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Premiums within thirty (30) days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. 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 (for Dependent Care Expense reimbursement, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, and dental coverage, accidental death and dismemberment coverage, and Medical Care Expense Reimbursement 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 ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits 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. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or a Dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution 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 gain 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 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.

- *Dependent Care Expense Reimbursement Benefits.* With respect to the Dependent Care Expense Reimbursement benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Accidental Death or Dismemberment (AD&D) Benefits.* For accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds AD&D insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of AD&D life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his AD&D life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child

(including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost.** If the Plan Administrator notifies you that the cost of your coverage under the Plan *significantly* increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to Health Care Expense Reimbursement accounts under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage.** If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly-

added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, 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 another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. (Please note that none of the above “Change in Coverage” exceptions are applicable to Health Care Expense Reimbursement accounts under the Plan.)

Additionally, the Plan’s Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-8. How are my Premium Payments Made?

When you become a Participant, your premiums will be paid with that portion of gross income that you have elected to forego through pre-tax salary reduction. The Employer will not be liable to you if an insurance company fails to provide any of the insurance benefits described above. Also, your insurance will end when: you leave employment (unless you make arrangements directly with the insurance carrier to continue coverage); you are no longer eligible under the terms of any insurance policy; or the Employer terminates the insurance plan.

Q-9. What if I terminate my employment during the Plan Year?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See the insurance booklets for information on your right to continued or converted coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

Q-10. Will I have any administrative costs under the Plan?

Administrative costs are currently covered by the employer.

Q-11. How long will the Plan remain in effect?

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

Q-12. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse and Dependents' right, to continue to be covered under any of the component medical benefit plans if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is --

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits;
- when a dependent of yours ceases to be a dependent.

For a Qualifying Event, other than a change in your employment status, it will be your obligation to inform the appropriate Plan Administrator of each medical benefit plan you have elected of its occurrence within thirty (30) days of the occurrence. The appropriate Plan Administrator, in turn, has a legal obligation to furnish you, or your Spouse, as the case may be, with separate, written options to continue the coverages provided at stated premium costs with respect to each health plan in which you are a participant. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

Certain Medical Care Expense Reimbursement Expense Account Participants will be eligible for COBRA Continuation Coverage if they have a positive Medical Care Expense Reimbursement Account balance (taking into account all submitted claims) at the time of a Qualifying Event. You will be notified if you are eligible for COBRA Continuation Coverage.

Q-13. What effect will Plan participation have on Social Security and other benefits?

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

Q-14. What is the Family and Medical Leave Act?

If your Employer is subject to the Family and Medical Leave Act ("FMLA") (generally, employers with at least 50 employees) and you are on eligible leave under FMLA, you may continue to pay for your Health Insurance coverages on an after-tax basis. If your Employer pays a portion of your Health Insurance premiums, it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the Health Insurance premiums. If your Employer is subject to FMLA, you should be provided with a complete explanation of your FMLA rights and responsibilities.

PART II

Medical Care Expense Reimbursement Benefits

You will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Expense Reimbursement Plan. Under this Plan, you purchase a specific level of Medical Care Expense Reimbursement benefits, paying for coverage through the Cafeteria Election Form with the Employer, in lieu of a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save social security and income taxes on the amount of the premiums you pay.

QUESTIONS & ANSWERS

Q-1. Who can participate in the Plan?

Each employee who is eligible for benefits is eligible to participate in the related Cafeteria Plan.

Q-2. How do I become a Participant?

By electing Medical Care Expense Reimbursement benefits during the Initial or Annual Enrollment Periods.

Q-3. What is my "Medical Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing Medical Care Expense Reimbursement Account ("Account" or "Health FSA") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year.

Q-4. What annual benefits are available under the Medical Care Expense Reimbursement Plan, and how much will they cost?

You may choose any amount of Plan Year reimbursement you desire subject to the maximum reimbursement amount of \$5000.00 per year. You will be required to pay the annual premium equal to the coverage level you have chosen.

Q-5. How is my Medical Care Expense Reimbursement benefit paid for?

When you complete the Cafeteria Election Form, you specify the amount of Medical Care Expense Reimbursement you wish to pay for with your salary reduction. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium deducted from each paycheck. The full amount of the coverage you

have elected will be available to reimburse you for your out-of-pocket medical expenses at any time during the Plan Year, so long as you continue to pay the premiums.

For example, suppose you have elected to be reimbursed for up to \$1,000 per year for Eligible Medical Expenses, and you have chosen no other benefits under the Cafeteria Plan. Your Account would be credited (and funded) with a total of \$1,000 during the Plan Year. If you are paid bi-weekly, your Account would reflect that you have paid \$38.46 per pay period in premiums for the benefit you have elected.

Q-6. What amounts will be available for Medical Care Expense Reimbursement at any particular time during the Plan Year?

Provided that you have continued to pay the periodic premiums due for this benefit, the full, annual amount of coverage you have elected will be available at any time during the Plan Year, reduced however by the amount of prior reimbursements received during the Year.

Q-7. How do I receive reimbursement under the Plan?

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. You must include written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with the Claim Form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) which you are obligated to pay.

If you have paid the premiums for the coverage you have elected, you will be reimbursed for your Eligible Expenses in the pay check that follows the pay period you submitted the claim. Remember, though, you can't be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You will have until April 15 after the end of the Plan Year in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year and Grace Period. You will be notified in writing if any claim for benefits is denied.

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 an amount due for an Eligible Medical Expense -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Q-8. What is an "Eligible Expense?"

Effective January 1, 2004, "Eligible Medical Expenses" means those items (including over-the-counter medications) incurred by the Employee, or the Employee's Spouse or Dependents, that are for "medical care" and for which you have not otherwise been reimbursed from insurance, or some other source. An over-the-counter medication is for medical care if it is needed to treat a medical condition and is generally accepted as falling within the category of medicine or drugs. The documentation to support the claim for reimbursement for the cost of an OTC drug must identify the name of the OTC drug that was purchased. Items that are merely beneficial to the general health of the individual are generally not for "medical care" and are not generally reimbursable (e.g., vitamins, nutritional supplements). However, even these drugs when taken at a doctor's suggestion to treat a specific medical condition may be reimbursable. Premiums for accident or health insurance coverage under any other plan are not Eligible Medical Expenses. Also expenses for long-term care are not eligible.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

Q-9. When must the expenses be incurred that I may be reimbursed for?

On May 18, 2005, the Internal Revenue Service issued Notice 2005-42 which authorizes employers to allow more time for employees who have flexible spending accounts (FSA) to use unused contributions. As a result, the University's Cafeteria Plan Summary Plan Description is hereby amended effective August 1, 2005, to provide for a "Grace Period" until March 15 immediately following the end of the 2005 cafeteria plan year (and subsequent cafeteria plan years) for employees to use unused contributions made in the prior calendar year. This Grace Period applies to all employees who participate in flexible medical reimbursement or dependent care accounts. What this means is that the deadline for incurring expenses has changed from Dec. 31 to March 15. Additionally, the deadline to file claims for the previous year's FSA has been changed from March 31 to April 15. Unused amounts in a medical reimbursement account cannot be used for dependent care expenses or vice versa.

The new Grace Period is effective for 2005. Therefore an employee who has a FSA for 2005 has until March 15, 2006, to use the monies. The new changes allow employees who might otherwise be rushing to spend remaining account balances this December or lose their funds to use 2005 deferrals to cover expenses through March 15, 2006. The following example demonstrates the new changes.

Example: James is scheduled to contribute \$2000 in CY 2005 to his medical FSA. In December, 2005, James has only had medical expenses of \$1500. He has until March 15, 2006, to go to the doctor, etc. to use the remaining \$500. If he has not used the full \$2000 by March 15, 2006, he will lose any unused amount. He must file his claim for

reimbursement with Glynn Griffing and Associates by April 15, 2006. If he has not filed his claim by April 15, 2006, he will lose any unclaimed amount.

You may not be reimbursed for any expenses arising before the Plan became effective, before your Cafeteria Election Form becomes effective, or except for Continuation Coverage, after a separation from service.

Q-10. What if the medical expenses I incur during the Plan Year and Grace Period are less than the annual amount I have elected for Medical Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual medical expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by April 15 following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-11 What Happens to Unclaimed Reimbursement Account Benefits?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by April 15 following the Plan Year and Grace Period in which the Health Care Expense was incurred shall be forfeited.

PART III

Dependent Care Expense Reimbursement Benefits

You may elect to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Expense Reimbursement Plan ("DCR"). Under these provisions, you provide a source of pre-tax funds to reimburse yourself for your Eligible Dependent Care Expenses by entering into a Cafeteria Election Form with your Employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is nontaxable; you save social security and income taxes on the amount of your salary conversion.

Questions & Answers

Q-1. Who can participate in the Plan?

Each Employee who is eligible for benefits is eligible to participate in the related Cafeteria Plan.

Q-2. How do I become a Participant?

By electing DCR benefits during the Initial or Annual Enrollment Periods.

Q-3. What is my "Dependent Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing Dependent Care Expense Reimbursement Account ("Account") will be set up in your name to keep a record of the reimbursements you are entitled to.

Q-4. What is the maximum DCR benefit I may elect?

This amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently \$5,000 per Plan Year if you -

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DCR, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

If you are married, reside together, but file a separate federal income tax return, the maximum DCR benefit you may elect is \$2,500.

Q-5. How is my Account funded?

When you complete the Cafeteria Election Form, you specify the amount of DCR benefits for which you wish to pay with your salary reduction. Thereafter, your Account will be credited with that portion of your gross income you have elected to forego through salary reduction. These portions will be credited as of each pay period.

For example, suppose you have elected to be reimbursed for \$2,600 per year for Eligible Employment Related Expenses, and you have chosen no other benefit under the Employer's Cafeteria Plan. Your Account would be credited (and funded) with a total of \$2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of \$100.00 credited to your Account each payday to pay reimbursements under this Plan. The amount that is available to your Account at any particular time will be whatever has been credited to such Account less any reimbursements already paid.

Q-6. What is an "Eligible Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13, who resides with you and for whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself; or your Spouse, if the Spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet all of the following conditions for them to be Eligible Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies or within the Grace Period.
2. Each individual for whom you incur the expenses is
 - (A) a Dependent age 12 or under whom you are entitled to a personal tax exemption as a dependent, or
 - (B) a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp

are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.
7. This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:
 - (a) \$5,000.
 - (b) \$2,500, if you are married but you and your Spouse file separate tax returns.
 - (c) Your taxable compensation (after your salary reduction under the Cafeteria Plan).
 - (d) If you are married, your Spouse's actual or deemed Earned Income.

For purposes of (d) above, your Spouse will be deemed to have Earned Income of \$200 (\$400 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time Student.

8. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-7. How do I receive reimbursement under the Plan?

On May 18, 2005, the Internal Revenue Service issued Notice 2005-42 which authorizes employers to allow more time for employees who have flexible spending accounts (FSA) to use unused contributions. As a result, the University's Cafeteria Plan Summary Plan Description is hereby amended effective August 1, 2005, to provide for a "Grace Period" until March 15 immediately following the end of the 2005 cafeteria plan year (and subsequent cafeteria plan years) for employees to use unused contributions made in the prior calendar year. This Grace Period applies to all employees who participate in flexible medical reimbursement or dependent care accounts. What this means is that the deadline for incurring expenses has changed from Dec. 31 to March 15. Additionally, the deadline to file claims for the previous year's FSA has been changed from March 31 to April 15. Unused amounts in a medical reimbursement account cannot be used for dependent care expenses or vice versa.

The new Grace Period is effective for 2005. Therefore an employee who has a FSA for 2005 has until March 15, 2006, to use the monies. The new changes allow employees who might otherwise be rushing to spend remaining account balances this December or lose their funds to use 2005 deferrals to cover expenses through March 15, 2006. The following example demonstrates the new changes.

Example: James is scheduled to contribute \$2000 in CY 2005 to his medical FSA. In December, 2005, James has only had medical expenses of \$1500. He has until March 15, 2006, to go to the doctor, etc. to use the remaining \$500. If he has not used the full \$2000 by March 15, 2006, he will lose any unused amount. He must file his claim for reimbursement with Glynn Griffing and Associates by April 15, 2006. If he has not filed his claim by April 15, 2006, he will lose any unclaimed amount.

If you have elected to participate in this portion of the Plan, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. If there are enough credits to the Dependent Care Expense Reimbursement Account, you will be reimbursed for your eligible expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Account. You may not be reimbursed for any expenses that arise before your Cafeteria Election Form becomes effective.

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 an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. You will be notified in writing if any claim for benefits is denied.

Q-8. What if the Eligible Employment Related Expenses I incur during the Plan Year and Grace Period are less than the annual amount of coverage I have elected for Dependent Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual coverage you have elected and paid for, on the other. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by April 15 following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs.

Q-9. Will I be taxed on the DCR benefits I receive?

You will not normally be taxed on your DCR benefits, up to the limits set out in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-10. If I participate in the DCR, 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, although the balance of your qualified dependent care expenses may be eligible for the dependent care credit.

Q-11. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$2,400 of such expenses for one Dependent, or \$4,800 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of \$720 for one Dependent or \$1,420 for two or more Dependents,) to a minimum of 20% of such expenses (producing a maximum credit of \$480 for one Dependent or \$960 for two or more Dependents.) The maximum 30% rate must be reduced by 1% (but not

below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross incomes over \$10,000.

Illustration: Assume you have one Dependent for whom you have incurred Eligible Expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$2,400 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 30% for each \$2,000 of your adjusted gross income over \$10,000. The calculation is: $30\% - [(\$20,000 - 10,000)/\$2,000 \times 1\%] = 25\%$. Thus, your tax credit would be $\$2,400 \times 25\% = \600 . If you had incurred the same expenses for two or more Dependents, your credit would have been $\$3,600 \times 25\% = \900 , because the entire expense would have been taken into account, not just the first \$2,400.

Q-12. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by including the DCR benefits in income, and claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat DCR benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits

Q-13. What Happens to Unclaimed Reimbursement Account Benefits?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by April 15 after the Plan Year and Grace Period in which the Dependent Care Expense was incurred shall be forfeited.

PART IV

Electing Less Than The Maximum Annual Benefit

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

PART V

General Information About Our Plan

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

1. General Plan Information

The University of Mississippi Cafeteria Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of the Plan described herein became effective on August 1, 2005.

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

2. Employer Information

Your Employer's name and address are:

The University of Mississippi
Paul B. Johnson Commons, East
University, MS 38677

3. Plan Administrator Information

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

The University of Mississippi
Paul B. Johnson Commons, East
University, MS 38677
(662) 915-7431

4. Service of Legal Process

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

The University of Mississippi
Paul B. Johnson Commons, East
University, MS 38677

Amendment to The University of Mississippi Cafeteria Plan Summary Plan Description –
Effective date of amendment: April 14, 2003

Use and Disclosure of Protected Health Information

A. The University of Mississippi will use protected health information (PHI) in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the university will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Treatment. PHI may be disclosed to health care providers including doctors, nurses, laboratory technicians, medical students and other health care professionals involved in the treatment of a health plan participant.

Payment includes activities undertaken by the university to obtain premiums or to fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom healthcare is provided. Examples include:

- *determination of eligibility, coverage, co-payments, and cost sharing amounts
- *adjudication of health benefit claims, appeals, and other payment disputes
- *establishing employee contributions
- *billing, claims management, and related health care data processing
- *reimbursement to the plan
- *justification of charges

Health Care Operations include, but are not limited to:

- *rating plan performance
- *activities relating to the creation, renewal, or replacement of a health related benefit
- *cost management and planning related analysis related to managing and operating health related benefit plans
- * business and general administrative activities of health related benefit plans.

B. The University of Mississippi will use and disclose PHI as required by law or as permitted in accordance with the written authorization of the participant or beneficiary.

C. The University of Mississippi is the Plan Administrator for the flexible medical reimbursement accounts. The University is the Plan Sponsor for dental, cancer and intensive care, long term care, hospital income, and other supplemental health related insurance plans provided by the University. *Please note that the University is neither the plan administrator, nor plan sponsor, for the State Group Health and Life Insurances. The State Department of Finance and Administration (DFA) is the Plan Administrator for the State Group Health Insurance. Questions regarding DFA's policies and procedures concerning PHI should be directed to DFA at 1.866.586.2781 or to Blue Cross and Blue Shield at 1.800.709.7881.*

D. As a Plan Sponsor, the University agrees to the following conditions:

- *not to use or further disclose PHI other than as permitted or required by the plan document or required by law
- *ensure that any agents, including a subcontractor, to whom the University provides PHI received from the health related plans, agree to the same restrictions and conditions that apply to the University
- *report to the Plan administrator any inappropriate uses or disclosures of PHI
- *make PHI available to an individual in accordance with HIPAA access requirements
- *make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA
- *make available the information required to provide an accounting of disclosures
- *make internal practices and records relating to the use and disclosure of PHI received available to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance with HIPAA
- *not to use or disclose PHI without prior written authorization from an individual in situations where an authorization form from said individual is required
- *if feasible, return or destroy all PHI received that the Plan Sponsor still maintains in any form, and retain no copies of such when no longer needed for the purpose for which disclosure was made. (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that made the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, the following employees or classes of employees may be given access to PHI (as these employees may receive or have access to PHI relating to treatment, payment under, health care operations, or other matters pertaining to the health related benefits plans in the ordinary course of business):

- *The University's Privacy Officer
- *Human Resources staff
- *Student Health Services staff
- *Employee Assistance Program Staff
- *Department of Communicative Disorders staff

F. Limitations of PHI Access and Disclosure

The persons described in Section E may only have access to, use of, and disclosure of PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

- *The University will maintain PHI separately from employee personnel files.
- *The University will control access to areas where PHI is stored and maintained in order to assure only those employees who have a need to know will be able to obtain access.
- *In an effort to limit the potential for receipt of PHI, University employees should refer requests for medical related information to the University Privacy Officer c/o of the Department of Human Resources.
- *Campus departments (other than those identified in Section E above) receiving PHI should forward it to the Department of Human Resources for proper storage and maintenance.

G. Noncompliance Issues

If the persons described in Section E or other University employees do not comply with the privacy requirements, the University shall provide a mechanism for resolving issues of noncompliance, including possible disciplinary action up to and including possible termination.

H. Questions or complaints regarding the use or disclosure of PHI, should be submitted to:

Attn: University Privacy Officer
The University of Mississippi
Department of Human Resources
Paul B. Johnson Commons, East
P.O. Box 1848
University, MS 38677
Ph. 662.915.7431
Fax: 662.915.5836
Email: hr@olemiss.edu