Roger Williams University and
Roger Williams University School of Law
FLEXIBLE SPENDING ACCOUNTS
Plan Document

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Plan Year: January 1, 2025 – June 30, 2025
Grace Period Ends: September 16, 2025
Claim Submission Period Ends: December 1, 2025

I. INTRODUCTION:

The health and welfare of you and your family are important to Roger Williams University and Roger Williams University School of Law and we recognize that safeguarding both is frequently a difficult and expensive task. To assist you with these types of expenses, we are offering you the opportunity to participate in a voluntary Flexible Spending Account (FSA). You can use your FSA to pay for IRS qualified healthcare, dependent care, and commuter expenses with before-tax dollars.

Funds in your FSA are deducted from your paycheck per pay period on a pre-tax basis. Please note that funding your FSA is voluntary.

This booklet has been written so that you will be aware of your rights and benefits. Every effort has been made to make the booklet as complete and accurate as possible. However, if any conflict should arise between this booklet and the Plan, the terms set by your employer will govern.

The FSA administrator is:

London Health Administrators
40 Commercial Way
East Providence, RI 02914
Phone #: 401-435-4700
Fax #: 401-435-3937
Website: www.londonhealthusa.com

The FSA plan sponsor contact information is:

Roger Williams University and Roger Williams University School of Law
One Old Ferry Road
Bristol, RI 02809
Phone #: 401-254-3028
TIN#: 050277222

The FSA plan's designated agent for services of legal process is:

Roger Williams University and Roger Williams University School of Law
One Old Ferry Road
Bristol, RI 02809
Phone #: 401-254-3028
Attn: Legal Council

II. GENERAL DEFINITIONS:

Account or Accounts means a Participant's Flexible Spending Account (FSA) maintained by the Employer under any Plan described herein, unless the context clearly indicates otherwise.

Benefit shall mean any qualified expense provided to a Participant.

Code shall mean the Internal Revenue Code of 1986, as amended.

Compensation shall mean the entire amount paid to an Employee during the Plan Year as salary, wages, commissions, overtime pay and bonuses, but excluding earnings prior to entering the Plan and benefits and credits under this or any other employee benefit Plan of the Employer.

Employee shall mean an employee of the Employer who is a participant in any Employee Benefit Plan.

Employee Benefit Plan shall mean programs sponsored by the Employer which are eligible for inclusion in a cafeteria plan under Code Section 125 Plan.

Employer shall mean Roger Williams University and Roger Williams University School of Law and any agency or political subdivision thereof authorized by the Employer to adopt and participate in this Plan.

Grace Period shall mean the time period of up to 2½ months after the end of the Plan year. If there is a grace period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year.

Highly Compensated Participant shall mean any employee defined in Code Section 125.

Key Employee shall mean any employee defined in Code Section 416(i)(1).

Participant shall mean any Employee who is qualified to participate in the Plan and is participating in the Plan.

Plan shall mean the FSA Plan of the Employer established pursuant to Code Section 125 as set forth in and by this document and all subsequent amendments thereto, unless the context clearly indicates otherwise.

Plan Administrator shall be London Health Administrators, Ltd.

Plan Name shall be Roger Williams University and Roger Williams University School of Law's Flexible Spending Accounts Plans.

Pledge Amount shall be the pre-tax contribution amount you elect to deduct from your paycheck to fund the Healthcare component of your FSA.

Qualified Benefit shall mean any benefit which is not includible in the gross income of the Employee by reason of an express provision of Chapter 1 of Subtitle A of the Code (other than Code Sections 117, 124, 127 or 132) and which is offered as a Benefit under this Plan.

III. INTRODUCTION TO YOUR FLEXIBLE SPENDING ACCOUNT (FSA)

Your contributions to the FSA can only be used to reimburse eligible healthcare, dependent care, and commuter expenses that you incur for yourself and/or eligible dependents during the Plan year. Expenses that you incur in excess of your account balance at the end of the Plan year cannot be reimbursed or carried forward for reimbursement in a subsequent Plan year. If employment should terminate during the FSA Plan year, all contributions to the spending account will cease, effective the date of termination. However, employees will be entitled to submit claims for eligible expenses through December 1, 2025 incurred January 1, 2025 to June 30, 2025, or until the account has been depleted, whichever comes first.

ELIGIBILITY AND PARTICIPATION

Eligibility employees are defined as: all employees enrolled in the employer's health insurance plan and full-time employees not enrolled in the employer's health insurance. Please note, part-time employees that want to enroll in the FSA must be enrolled in the employer's health insurance plan.

Any active employee is eligible to enroll as of the date of the employee's effective date. If you want to enroll in the FSA, you will need to complete and sign an Employee Enrollment Form, including the amount(s) to be deducted from your check each payroll period. Your signature on the Employee Enrollment Form authorizes Roger Williams University and Roger Williams University School of Law to make pre-taxed payroll deductions in the amount stated on the form. A new enrollment form must be signed every FSA Plan year.

The Plan year runs from January 1, 2025 and ends June 30, 2025. Amounts remaining in the account after the end of the Plan year are forfeited. However, you will have a grace period, which provides you with an additional two and half month (75 days) time frame after June 30th to use your Plan year FSA contributions.

ENROLLMENT PROCEDURES AND DEADLINES

Initial hire or benefits eligibility: An individual must enroll in the FSA Plan by completing the necessary enrollment process no later than 31 days from the date of hire or initial benefits eligibility. After hire or initial eligibility, an individual may elect FSA participation and/or change the amount of the contribution as a result of marriage, birth or adoption of a child provided the individual notifies the Benefits Division and completes the enrollment process within 31 days from the date of a change in family status. Eligible employees must re-enroll in the FSA Plan in order to continue participation for the next FSA Plan year.

CHANGES DURING THE PLAN YEAR

When you enroll in the flexible spending account, you decide how much money you want to deposit for the year. Generally, you cannot change the amounts until the next annual enrollment period. However, you may make changes during the year under special circumstances. According to the IRS, you can change your election amounts during the year only if you have a change in family circumstance. The following changes qualify as a change in family circumstance:

- Marriage or Divorce
- Birth or Adoption of a Child
- Death of a Spouse or Dependent
- Change in Employment Status of Spouse
- Change in status of Dependents
- The mother's return to work following the birth of a Child and upon incurring Childcare Expenses

If you experience a change in family circumstance, you will be permitted to make changes to your flexible spending account. This change in your flexible spending account must be made within 31 days of the change in family circumstance. You must complete an Employee Enrollment Form within the 31-day period notifying your employer of any of these changes.

PARTICIPANT TERMINATION

Each participant shall be a participant in the FSA for the entire FSA Plan year or the portion of the FSA Plan year remaining after the participant's entry date, if later than the first day of the Plan year. A participant shall cease to be a participant in the Plan on the earliest of:

- The date the participant dies, resigns or terminates employment with the employer;
- The date the participant fails to make required contributions under the Plan;
- The date the participant ceases to be an employee or otherwise becomes no longer eligible to participate under the terms of the Plan; or
- The date the Plan terminates

CONTRIBUTIONS

Contributions into your FSA are deducted from your paycheck per pay period on a pre-taxed basis. Your contributions are voluntary. Before the start of your Plan, you select an amount to be withdrawn from your paycheck each pay period. The maximum annual amounts you may contribute to the three components of the FSA are:

- Healthcare Account = $1,650 per year;
- Dependent Care Account = $2,500 per year;
- Commuter Account = $162.50 per month for parking and $162.50 per month transit expenses

Below are more rules governing your FSA contributions:

- Contributions are deducted from paychecks on a pre-tax basis. This means that the contribution amount is excluded from taxable earnings;
- Contributions are deducted from your paycheck per pay period;
- Individuals on a paid leave of absence may continue to pay contributions by payroll deduction. Individuals on an unpaid leave of absence may continue FSA participation and contributions by paying monthly contributions by check payable to Roger Williams University and Roger Williams University School of Law and submitted to the Benefits Division. The contribution amount must be the same amount as the individual was making prior to leave. An individual may continue to submit claims for services received prior to the leave;

HEALTHCARE ACCOUNT

Your FSA includes a Healthcare Account that is funded with pre-tax payroll deductions to help you pay for qualified healthcare expenses such as deductibles, copays, dental and vision expenses. The purpose of the Healthcare Account is to provide a tax-savings program for an individual to reimburse himself or herself for out-of-pocket expenses not covered by an individual's medical, dental or vision plans or a spouse's plans. The

expenses must be incurred by the participant or his or her eligible dependents (spouse and any children). To qualify, the dependent must be claimed as a tax exemption on the individual's federal income tax return.

In order to participate in the Healthcare component of your FSA, you must elect your pre-tax payroll contributions during the open enrollment period. During the Plan year, your full pledge amount is available on the first day of the Plan. The annual maximum amount you may contribute into you Healthcare Account is $1,650.

Qualified healthcare expenses must be incurred by the participant or his or her eligible dependents (spouse and any children) during the Plan year in order access your pre-tax Plan contributions.

The Healthcare Account includes a USE-IT-OR-LOSE-IT Rule. Any unused funds at the end of the FSA Plan year (January 1, 2025 to June 30, 2025 plus grace period) must be forfeited and cannot be returned in any manner.

Sample Qualified Healthcare Expenses:

- Ambulance
- Artificial Limb or Prosthesis
- Birth Control
- Chemical Dependency Treatment
- Chiropractors
- Contact Lenses
- Dental Expenses
- Diagnostic/Lab Fees
- Physician Fees
- Eyeglasses
- Eye Surgery
- Hearing Aids
- Hospital Services
- Prescription Drugs
- Smoking Cessation Programs
- Transplants
- Weight Loss Program

Sample Non-Qualified Healthcare Expenses:

- Cosmetic Surgery
- Deodorant
- Electrolysis of Hair Removal
- Health Club Dues
- Medicated Shampoo and Soap
- Mouthwash
- Multivitamins
- Teeth Whitening
- Tissues
- Toiletries

DEPENDENT CARE ACCOUNT

Your FSA also allows you to pay for dependent care expenses. The purpose of the FSA Dependent Care Account is to provide a tax-savings program to assist eligible individuals to fund work related dependent care expenses such as day care centers or in-home child care providers. According to Section 125 of the IRS code you can contribute up to $2,500 (or $1,250 if married and file separate income tax returns) into your Dependent Care FSA to be used for these expenses. You make pre-tax deductions to your FSA for dependent care expenses from your paycheck. Your tax savings are realized throughout the Plan year with every paycheck you receive.

The following is a summary of the general eligibility requirements for individuals to participate in the Dependent Care Account. An individual must meet one of the following requirements:

- The individual is a single parent, or
- The individual has a working spouse, or
- The spouse is a full-time student for at least five months during the year while an individual is working, or
- The spouse is disabled and unable to provide for his or her own care, or
- The individual is a divorced or legally separated parent who has child custody most of the time – even though the other parent may claim the dependent for tax purposes.

The following is a summary of the general eligibility requirements for dependents to participate in the Dependent Care Account. Eligible dependents include:

• Any child under age 13 who is claimed as a dependent for federal income tax purposes.

• Any other dependent that is claimed as a dependent for federal income tax purposes and who normally spends at least eight hours in the home each day and who is unable to care for himself or herself because of a physical or mental disability. The person may be a child age 13 or over, a spouse, a parent, etc.

Sample Qualified Dependent Care Expenses:

- Dependent care center, babysitter, nanny
- Care of an eligible dependent under age 13
- Care of an eligible dependent of any age who is physically or mentally incapable of caring for herself or himself

Sample Non-Qualified Dependent Care Expenses:

- Care expenses not incurred in order for you to work or look for work, such as expenses incurred while you are on any leave of absence
- Care expenses not incurred in order for your spouse to work, look for work, or be a full-time student
- Kindergarten or other educational expenses
- Instructional camps, sport specific camps, or overnight camps
- Food, transportation or activity fees
- Care for a child for whom you have 50% or less physical custody
- Care for a child age 13 or older who is not disabled
- Child support payments
- Amounts paid to your spouse
- Amounts paid to your dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year

The IRS permits a participant to take a federal tax credit on his or her annual income tax return for dependent care expenses. However, the amount deposited to the Dependent Care Account will reduce, dollar-for-dollar, the amount used toward the federal tax credit. For some individuals, the tax savings is greater if they pay for dependent care expenses through the reimbursement account. For others, it is greater if they take a tax credit on their annual income tax returns. Individuals are encouraged to consult a credible tax advisor if there are any questions about whether the reimbursement account or tax credit is more advantageous.

TRANSPORTATION ACCOUNT

Your FSA can also be used to pay for eligible transportation expenses related to your commute to and from work. The purpose of the FSA Transportation Account is to provide a tax-savings program to help eligible individuals to fund work related mass transit expenses such as bus passes. According to Section 125 of the IRS code you can contribute up to $162.50 per month for parking and $162.50 per month for transit expenses.

Sample Qualified Transportation Expenses:

- Bus vouchers and passes used to commute to and from work
- Vanpooling in a “commuter highway vehicle” to and from work so long as 80% of mileage is for transportation of employees between work/home and the vehicle is at half the maximum adult seating
- Ferry passes used to commute to and from work

Sample Non-Qualified Transportation Expenses:

- Mass transit costs not associated with the commute to and from work
- Mass transit costs from an employee bought voucher or bus pass when a voucher system is already sponsored or available by the Employer
- Expenses incurred before FSA Plan was established

NON-DISCRIMINATION

The Plan, in accordance with applicable provisions of the Code, is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or benefits. The Plan administrator may take such action as it deems appropriate or necessary to ensure that the Plan is not deemed a discriminatory plan under applicable provisions of the Code.

PLAN ADMINISTRATION

London Health Administrators Ltd. shall administer the FSA and shall have the authority to exercise the powers and discretion conferred by the Plan and shall have such other powers and authority necessary or proper for the administration of the Plan as shall be determined from time to time. Roger Williams University and Roger Williams University School of Law sets the rules and regulations that govern the FSA Plan.

Roger Williams University and Roger Williams University School of Law may adopt such rules and regulations for the administration of the Plan as it shall consider advisable and shall have full power and authority to enforce, construe, and interpret the FSA. All interpretations under the Plan and all determinations of fact made in good faith by the employer shall be binding on the participants, their dependents, and all other interested persons.

Roger Williams University and Roger Williams University School of Law may delegate to any agent, attorney, accountant, or other person selected by it, any power or duty vested in, imposed upon, or granted to it by the Plan.

Neither Roger Williams University and Roger Williams University School of Law nor London Health Administrators may make any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for Federal, state or local tax purposes, or that any other Federal, state or local tax treatment will apply to or be available to any participant. It shall be the obligation of each participant to determine whether each payment under the Plan is excludable from the participant's gross income for Federal, state and local income tax purposes, and to notify the employer if the participant believes that any payment is not so excludable.

FUNDING AND PAYMENT OF FSA BENEFITS

Funds in the FSA are accessible to you by using your MasterCard or by submitting claim forms to London Health Administrators, Ltd.

The following is a summary of how reimbursement is accessed:

(a) *MasterCard:* At the time of service present your health insurance card first. When asked for payment, swipe your MasterCard to process the transaction. Please note that London Health Administrators audits every MasterCard claim. If the Plan administrator believes a transaction via your MasterCard is an ineligible healthcare expense then London will request more information about the claim from you.
(b) Submitting a Manual Claim to London Health Administrators: File a manual claim with London Health Administrators by completing and submitting a claim reimbursement form. You must include with the claim form

a written statement from an independent third party, (e.g. a receipt, EOB, etc.) associated with each expense that indicates the following:

- The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

When submitting information for manual reimbursement, please mail, fax or email all claim forms, EOBs, receipts, etc. to the Plan administrator at:

London Health Administrators
40 Commercial Way, East Providence, RI 02914
Fax #: 401-435-3937

Reimbursement for expenses that are determined to be eligible expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "eligible expense" you will receive notification of this determination. You must submit all claims for reimbursement for eligible expenses by December 1, 2025 incurred from January 1, 2025 to June 30, 2025.

SUBSTANTIATION

London Health Administrators audits all claims processed through your FSA. If an expense is deemed not eligible upon review by a London Health claim examiner your claim will be denied. If you wish to appeal the denial you must follow the claims appeal process stated within this plan document.

If you use your FSA MasterCard for an ineligible expense, London will send you a letter requesting: 1) more information about the claim or 2) a refund from you for the amount of the ineligible expense. A second letter will be sent if London does not hear back from you within 30 days. A third letter will be sent if London does not hear back from you within another 60 days. If London does not hear back from you within 90 days from the initial letter of request then your FSA MasterCard will be deactivated. Your card will be reactivated when you respond to the letter of request in regards to the ineligible expense. During this substantiation period you will be able to file FSA claims for manual reimbursement.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this FSA includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA).

An individual may elect to temporarily continue participation in the Plan for expenses incurred after the termination date. Contributions for this period must be made on an after-tax basis and must be the same per pay period amount as was being contributed prior to termination.

Under COBRA, participation in the Plan may be continued through the end of the Plan year in which termination of employment occurs.

Contributions must be made by check, once per month, on an after-tax basis. Therefore, during the continuation period, an individual is not eligible for the pre-tax reductions in taxable income and income taxes that applied during active employment.
The COBRA procedures for notifying an individual of his or her continuation rights are as follows:

- The Benefits Division will notify an individual of continuation rights within 14 days of termination of employment.

- The individual has 60 calendar days from the date the notice is received to return a signed election form.
- An individual has 45 calendar days from the date the election form is received to pay the first deposit. That check should cover the period which runs from the employment termination date through the end of the current month.

Each subsequent monthly deposit is due on the first day of the month.

MILITARY SERVICE

If you serve in the United States armed forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

For any leave, and solely to the extent the provisions of the Family and Medical Leave Act of 1993 (FMLA) apply and such leave qualifies as a FMLA leave, the member may remain an active member and shall be entitled to receive the same benefits as before the start of the FMLA leave, subject to the continued payment of any required contributions under the FSA Plan.

EFFECTS OF THE PLAN ON OTHER BENEFITS

The salary dollars you contribute to the FSA Plan are not subject to Federal, State or FICA taxes, and will not be included in the income reported on your W-2 form. For the purpose of determining these benefits, your salary will be based on your earnings before any salary reduction contributions are made to the FSA Plan.

However, under present law, your earnings for the purpose of determining your Social Security benefits do not include salary reduction contributions made under the Flexible Spending Account Plans. In almost all cases, the value of the FICA, Federal and State income tax savings to you should substantially exceed the reduction in your eventual Social Security benefits.

RULES FOR FLEXIBLE SPENDING ACCOUNT CLAIMS

1. All manual claims must be accompanied with a completed claim form.

2. Dates of services for all reimbursable expenses must be in the current Plan year, which is January 1, 2025 through June 30, 2025 plus grace period.

3. Manual claims for expenses which are coverable expenses under employee's health or dental insurance plan must be submitted to employee's insurance company for action before being sent for reimbursement from the Flexible Spending Account. The insurance company's Explanation of Benefits must accompany such claims.

4. Manual claims that have been paid with your personal funds must be accompanied by a paid receipt. These receipts must provide the date of service, type of service, individual charges and the amount paid.

5. Participants are not permitted to change election amounts until the next calendar year, except for 31 days after the following changes in family circumstances: Change in Marital Status (Marriage or Divorce), Death of a Spouse or Child, Change in the Employment Status of Spouse, Birth / Adoption of a Child, The mother's return to work following the birth of a Child and upon recurring Childcare Expenses.

IV. CLAIMS APPEAL PROCESS

If you are denied a benefit under the FSA Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from London Health Administrators, Ltd.* If your claim is denied, you will receive written notice from the Plan Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of London Health Administrators, Ltd., the Plan Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the London Health Administrators, Ltd. must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from London Health Administrators, Ltd., review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- if London Health Administrators, Ltd. relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy will be provided upon request and free of charge.
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of London Health Administrators, Ltd., you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. You should file your appeal with the Plan Administrator. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Claims Reviewer.* If the claim is again denied, you will be notified in writing. London Health Administrators, Ltd. will send the notice no later than 30 days after receipt of the appeal.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by London Health Administrators, Ltd.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Plan Administrator's decision, file a 2nd Level Appeal.* If you still do not agree with the Plan Administrator's decision, you may file a written appeal with your employer within 60 days after receiving the first level appeal denial notice from London Health Administrators, Ltd. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures

V. YOUR RIGHTS UNDER ERISA

As a covered employee under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

1. Examine, without charge, at the Employer's office all Plan documents, including those filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Employer is required by law to furnish each participant with a copy of this summary financial report.

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

5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health benefit plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health benefit plan or health 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 a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for you and your dependents, ERISA imposes duties upon the people who are responsible for the operation of the 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 covered employees and their dependents. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a Medical Expense is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Claims Administrator and/or the Employer 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 Employer 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 Employer.

If you have a claim for benefits, which is denied or ignored in whole or part, you may file suit in a state or 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.

If you have any questions about the Plan, you should contact the Employer. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20260. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

VI. HIPAA PRIVACY

London Health Administrators and your employer understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

The following categories list the different ways that we use and disclose medical information; for treatment (as described in applicable regulations), for payment (as described in applicable regulations) and for health care operations (as described in applicable regulations).

In addition, as required by law, we will disclose medical information about you when required to do so by Federal, State or local law or to avert a serious threat to health or safety. Other uses and disclosures of medical information not listed in this Notice or the laws that apply to us will be made only with your written permission.

If you would like more information on your FSA call London Health Administrators at 401-435-4700.