

**SECTION 125 CAFETERIA PLAN
ADMINISTRATIVE AND
CLAIMS PROCESSING INFORMATION
MEDICAL REIMBURSEMENT ACCOUNT**

I. CAFETERIA PLAN OVERVIEW

Participation in the Cafeteria Plan allows you to use pre-tax rather than after-tax dollars to pay for your share of employer sponsored insurance premiums (medical, dental, vision, life, VADD, and other coverages). Premium payment is a simple payroll adjustment which is handled internally by your employer's payroll department.

II. GENERAL ADMINISTRATIVE RULES

The following rules have been formulated to administer Section 125 Cafeteria Plans in accordance with Section 125 of the Internal Revenue Code and the appropriate regulations published thus far by the Internal Revenue Service. They are:

1. You will be terminated from the Plan upon your termination of employment unless you elect COBRA coverage in the Medical Reimbursement Account under the Cafeteria Plan.
2. You may not change contributions or benefit selections during a Plan year without a "change in status" or the occurrence of another event as described in the Treasury Regulation (contact your Benefits Manager for your company policy on this matter).
3. Any change made due to "change in status," must be consistent with the type of change; meaning that the election has to be made on account of, and correspond with, a change in status affecting eligibility under the Plan.
4. You may not drop or re-enroll in the Cafeteria Plan during a Plan year except in limited situations resulting from a "change in status", a significant cost or coverage change, or other exceptions that are defined in the IRS Code Regulations or the Family and Medical Leave Act (FMLA).
5. During a FMLA or any other approved unpaid leave of absence, special procedures apply to the contributions to your reimbursement accounts and insurance premium deductions. You should discuss your situation thoroughly with your Human Resource representatives prior to the leave of absence period. This discussion must be completed well in advance of leave of absence period to ensure proper handling of your payroll deductions for premiums and contributions.
6. You may increase or decrease your premium contributions due to a significant premium change during a Plan year, but only to the extent of the premium change; a cost increase or decrease refers to an increase/decrease in the amount of the employee's elective contributions under the Plan.
7. If a Plan adds a new benefit option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, the Plan may permit "eligible employees" (whether or not they have previously made an election under the Plan or have previously elected the benefit package option) to revoke their election under the Plan and elect coverage under the new or improved benefit package option. A significant improvement in a benefit package option includes a significant decrease in the cost of a qualified benefits plan.
8. You may elect similar coverage in response to a significant curtailment in coverage on your or your spouse's benefit package. If there is a significant curtailment in coverage that does not constitute a loss of coverage, an employee may not drop coverage. If the significant curtailment in coverage does amount to a loss of coverage, the Plan may permit the employee to revoke his election under the Plan and to elect either to receive coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available.
9. An employee may add coverage under this Plan if the employee/spouse/dependent loses coverage under a group health plan sponsored by a governmental or educational institution including:
 - State's children's health insurance program under Title XXI of the Social Security Act;
 - A medical care program of an Indian Tribal government;
 - A state health benefits risk pool;
 - A foreign governmental group health plan.

II. GENERAL ADMINISTRATIVE RULES (continued)

10. An employee can make a mid-year election change corresponding with an open enrollment period change made by a spouse or dependent when the Plan of that individual's employer has a different period of coverage than the employee's.
11. If a spouse or dependent makes an election change under a Cafeteria Plan maintained by his/her employer, the employee can make an election change as long as the spouse/dependent's change satisfies regulations.
12. Termination and resumption of employment can allow an employee to resume participation within certain limitations as established by the Plan Administrator.
13. An Employee can elect to enroll pre-existing dependent(s) into a group health plan in accordance with HIPAA special enrollment rights.
14. If an employee can elect family coverage under a group health plan when there is a new spouse or dependent, then other family members are permitted to become covered under the family coverage.
15. A change in Medicare or Medicaid entitlement of employee, spouse of dependent will allow the employee to change health coverage.
16. Any amount left in your Medical Reimbursement Account at the end of a Plan year will be forfeited. After the Plan year ends, a ninety (90) or one hundred-twenty (120) day runout period is given to active and terminated employees to allow filing of the appropriate documentation for reimbursement of expenses incurred during the just completed Plan year.
17. No reimbursement will be made until the first account deposit is received from your employer.
18. You must re-enroll prior to each new Plan year and you may make changes to your benefit selections at that time.
19. **CHANGE IN STATUS** (as defined in Section 125 of the Internal Revenue Code)

If an employee experiences a change in status during the course of the Plan year, then he or she will be permitted to revoke existing benefit elections and make new elections based on that change in status. The revocation or new selection must be consistent with the change in status and must be made within thirty (30) days of the change in status. **A CHANGE IN ELECTION STATUS MUST BE A PROSPECTIVE AND NOT A RETROSPECTIVE CHANGE.** In addition, an employee who has dropped or changed coverage because of an unpaid leave taken under the Family and Medical Leave Act will have thirty (30) days after returning from leave to re-enroll in the Plan. The following circumstances constitute changes in status:

- Qualified Domestic Relation Orders - only if the spouse, former spouse or other individual actually provides accident or health coverage for the child
- Death of Spouse or Child
- Birth or Adoption of Child
- Change of Employment or Martial Status* of Employee, Spouse or Dependent
- Change in number (increase/decrease) of an employee's family members or dependents who may benefit from coverage under the Plan
- Qualified Medical Child Support Orders
- Strike or lockout
- Commencement of or return from an unpaid leave of absence
- Event causing an employee's dependent to satisfy eligibility requirements
- A change in the number of qualifying individuals is a change in status for dependent care assistance.
- Other circumstances which the Plan Administrator within his/her discretion determines to be permitted by the Regulations and the Plan Document.

*An employee can make an election change from family coverage to employee-only coverage only if his/her spouse makes an election change to cover their child under his/her employer's plan.

III. MEDICAL REIMBURSEMENT ACCOUNT OVERVIEW

You may elect to designate before-tax dollars to the Medical Reimbursement Account for eligible, out-of-pocket family medical expenses incurred during the Cafeteria Plan Year. These reimbursement dollars become a non-taxable benefit for you and will be reimbursed directly to you when you submit properly documented claims for eligible expenses. Eligible expenses include most items (except insurance premiums) that are considered deductible expenses on a Federal Income Tax Return. Under most circumstances this account is an eligible benefit under COBRA. Please consult with your Benefits Manager to determine whether this account is available to you under COBRA.

EXAMPLES OF ELIGIBLE MEDICAL EXPENSES

- Acupuncture
- Alcohol and Drug Rehabilitation Expenses
- Ambulance
- Artificial Limbs
- Birth Control Devices (Prescription Drugs)
- Braille Books and Magazines
- Chiropractor
- Christian Science Practitioners
- Certain Corrective Surgery (Non-Cosmetic)
- Coinsurance
- Contact Lens, Solutions, and Other Items Used for the Upkeep of Contact Lenses
- Crutches
- Deductibles
- Dental Care and Dentures
- Examinations
- Eyeglasses and Examinations
- Guide Dog
- Gynecologist
- Rental or Purchase of Medical Equipment Including Special Equipment for use by Disabled Persons
- Surgery (Legal)*
- Hearing Aids and Batteries
- Hospital and Skilled Nursing Facility Expense
- Home Health Care
- Insulin, Needles, Syringes and Items Related to Diabetes
- Laboratory Fees
- Lip Reading Lessons
- Obstetrical Expense
- Operations and Related Treatment
- Optometrist
- Orthodontist**
- Outpatient Clinic
- Pediatrician
- Physician
- Podiatrist
- Practical Nurses
- Prescription & Over-the-Counter Medications***
- Psychiatrist
- Psychologist
- Support of Corrective Devices
- Therapy
- Well Baby Care
- Weight-Loss Programs****
- X-ray

For a listing of eligible expenses under the Medical Reimbursement Account, please visit www.irs.gov and print Publication 502.

* Certain cosmetic surgical procedures directed at improving a patient's appearance and not to treat an illness or promote proper functions of the body are not reimbursable items. Procedures necessary to improve birth defects, disfiguring disease, accidents or traumas are allowed. Laser Eye Surgery - Amounts paid for radial keratotomy or other eye surgeries for functional correction of the eye are covered. Participants planning on laser surgery should verify if they are an appropriate candidate prior to participating in the Plan or increasing their Plan year benefits.

** We cannot accept a claim for the entire contracted amount. We will accept claims for the initial down payment usually associated with the appliance. Monthly payments will also be accepted as the charge for the dental services rendered or that month. We will need a copy of the orthodontia contract for your file.

*** Does not include drugs prescribed for hair growth. Certain over-the-counter (OTC) drugs or items available without a prescription may be reimbursable. Ameritas may require proof of medical necessity and diagnosis, signed by the monitoring physician (substantiation). This expense is only considered if the Employer Group has agreed to participate in OTC reimbursements. Contact Ameritas to determine if your Employer Group allows OTC items for reimbursement. A listing of acceptable over-the-counter medications is available at www.Ameritas.net.

**** Includes the cost of a weight-loss program undertaken at a physician's direction and monitored by the physician to treat an existing disease (e.g. heart disease). Medication prescribed as part of this program is an eligible expense. (Ameritas may require proof of medical necessity, including diagnosis and treatment plan, signed by the monitoring physician.) You cannot include the cost of a weight-loss program if the purpose of the weight control is to maintain your general good health. Programs such as Weight Watchers, Jenny Craig, Nutri-Systems and other national chains do not qualify as an eligible physician monitored program.

IV. CLAIMS SUBMISSION PROCEDURES

1. A participant must make a claim for Medical Reimbursement Account expenses by PROPERLY completing a claim form. Claim forms may be requested from the Plan Administrator or may be printed from the Ameritas website at www.ameritasgroup.com. Fast claim envelopes are also available from Ameritas.
2. Claims for Medical Reimbursement Account expenses are processed daily Monday through Friday, except holidays. The processing turnaround time is 7-10 working days from the date the claim is received in Ameritas' office assuming proper documentation and funds availability.
3. Services must be rendered during the Plan year for which you enroll. If you are a new employee entering the Plan during a Plan year, services must be rendered after your eligibility date. Claim payments are based on the date the services are provided and not the date of the bill. Prepayment of expenses will not be reimbursed.
4. Claims may be submitted at any time during the Plan Year. An additional ninety (90) days will be provided at the end of the Plan Year. Some plans may offer a grace period at the end of the Plan year, which will allow one hundred-twenty (120) days after the end of the Plan year to submit claims. Contact your Benefits Manager to determine if your plan qualifies. A terminated employee must have incurred the expenses within the same Plan Year, but prior to their date of termination, and will be provided an additional ninety (90) days at the end of the Plan Year.
5. To expedite the processing of your claim, it is recommended that, if an expense is covered by your health insurance plan, you submit your bills to the insurance company first, then submit the insurance company's Explanation of Benefits (EOB) along with your Ameritas claim form. You should only request reimbursement for those charges not covered by your health insurance plan. HMO health plan participants must submit an itemized statement from their provider as described in paragraph 6. below.
6. For expenses not covered by your health insurance plan or for HMO plan participants, please submit an itemized statement received when the service was provided. The itemized statement must show the date of service, the name of the provider, type of service, and charges for the service. Indicate on the signed claim form that the service was not covered by your health insurance plan.
7. Premiums paid for health insurance cannot be reimbursed through the Medical Reimbursement Account.
8. When filing claims for reimbursable expenses, retain a copy of your filing for income tax purposes.

V. DOCUMENTATION FOR MEDICAL REIMBURSEMENT CLAIMS

1. ACCEPTABLE DOCUMENTS

- (a) An Ameritas claim form with each submission, and
- (b) If you have no health insurance coverage, submit an itemized statement from the provider that includes:
 - (1) Name of provider
 - (2) Type of service provided
 - (3) Original date(s) of service
 - (4) Charge(s) for service; or
- (c) If you have health insurance coverage, submit the Explanation of Benefits (EOB) from the Insurance Company for the eligible expenses not covered by the health plan carrier. HMO health plan participants must submit an itemized statement from their provider; or
- (d) A pharmacy statement that includes the prescription date, the name of the prescription and the charge for the prescription; or
- (e) Cash Register Receipts for Over the Counter Items. The receipts must show the name of the item, the date the item was purchased, the quantity purchased and the charge for the item.

2. UNACCEPTABLE DOCUMENTS:

- (a) Canceled checks;
- (b) Bills or receipts that show balances forward or previous balance;
- (c) Cash register receipts.

If you have any questions about your Medical Reimbursement Account, you may call our Customer Service Department at (210) 357-1010 or (800) 229-1024 if outside of the San Antonio area.

BE CONSERVATIVE! UNCLAIMED DOLLARS WILL BE FORFEITED