

**SECTION 125 CAFETERIA PLAN
ADMINISTRATIVE AND
CLAIMS PROCESSING INFORMATION
DEPENDENT CARE ASSISTANCE 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 and Dependent Care Accounts 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. DEPENDENT CARE ACCOUNT OVERVIEW

You may elect to designate before-tax dollars to the Dependent Care Assistance Account for eligible child or adult care expenses 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. You may designate up to \$5,000 per Plan Year into this account, or \$2,500 if married but filing single. Tax credits may not be taken in conjunction with this account.

A. WHAT ARE THE REQUIREMENTS?

Services for the care of dependents under age 13 or totally incapable of self-care (such as a child, spouse or parent), qualify for reimbursement based on the following:

- IF:
- You are single, or
 - You and your spouse both are gainfully employed, or
 - Your spouse is a full-time student or totally incapable of self-care
- AND:
- The dependent care cost is incurred in the Plan Year or the immediately following two and half month grace period (if available) to enable you to be employed, and
 - The service is provided by someone who is not your dependent for tax purposes, and
 - If the service is provided outside your home by a facility that cares for six or more children, it must be a qualified daycare that meets all local and state regulations.

B. SECTION 125 DEPENDENT CARE RULES

1. Unpaid volunteer work or volunteer work for a nominal salary does not qualify.
2. If the expense is for Nursing Home Care, the eligible dependent must spend at least eight hours a day in your home.
3. Your dependent care expense must be incurred to allow you (and your spouse if you are married) to work or look for work. (There are special rules relating to student spouses and disabled spouses.)
4. You must have income from work during the year.
5. You must have made payments for dependent care to someone you could not claim as a dependent, and if the person you made payments to was your child, he or she must have been age 19 or over by the end of the tax year.
6. Child support payments and child care payments qualifying as alimony are not qualified expenses for reimbursement.
7. The dependent care center or provider must comply with all the applicable federal, state and local regulations.
8. The cost of transporting a qualified dependent to and from your home and the care locations is not an eligible expense.
9. A claim submission for expense reimbursement must contain the name, address, and taxpayers' identification number of the person, organization or entity to which the expense was or is to be paid. Also, the claim must include the amount, date and nature of the expenses with respect to the benefit reimbursement requested.
10. Such claim submission must be accompanied by the provider's statements describing the amounts of such expenses, together with any additional documentation which the Plan Administrator may request.
11. In the event of a termination of coverage because of the Employee's taking of an unpaid leave of absence, the Employee electing to terminate coverage under this Plan shall not be permitted to participate in the Plan upon return from the unpaid leave within the same Plan year in which the leave commenced, unless the leave is taken under the provisions of the Family and Medical Leave Act of 1992.
12. A change of dependent care provider allows a corresponding election change when one dependent care provider is replaced by another whether or not the provider is related to the employee. Cost change rules do not apply if the provider is a relative of the employee.

C. QUALIFYING DEPENDENT

A qualifying dependent is defined for this purpose as any individual who lives with you for more than half the year and who is:

1. a child up to age 13 who does not provide more than half of his or her support; or
2. your spouse or anyone for whom you can claim a dependency exemption on your tax return, if a person is physically or mentally incapable of caring for himself or herself.
3. You must be the custodial parent and the child must live in your home.

D. ELIGIBLE DEPENDENT CARE EXPENSES

If dependent care is required to enable you (or a spouse or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools, and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child of the taxpayer who has not reached age 19 by the end of the year), or a non-relative, as long as such a person is reporting payments as income, is also eligible.

- Nursery, baby-sitting, private Pre-K and extended day care before and after school.
- Adult care (age 13 and older and totally incapable of self-care)

E. INELIGIBLE DEPENDENT CARE EXPENSES

Private first grade and above is considered as education and does not qualify as child care.

- Swimming and piano or other lesson
- Workbooks or other supplies
- Overnight camps
- Kindergarten
- Field trips

Additional information regarding eligible expenses is available to you by visiting www.irs.gov and printing Publication 503.

IV. CLAIMS SUBMISSION PROCEDURES

1. A participant must make a claim for Dependent Care Account expense reimbursement 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 Dependent Care expense reimbursement 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. 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. When filing claims for reimbursable expenses, retain a copy of your filing for income tax purposes.

V. REQUIRED DOCUMENTATION FOR DEPENDENT CARE CLAIMS

1. ACCEPTABLE DOCUMENTS:

Provider's statement with name and address of provider, provider's tax identification number or social security number, amount paid, names for whom services were provided and inclusive of dates of services (days, weeks, month, i.e., 10/6/97 through 10/10/97).

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 Dependent Care 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.