Loyola Marymount University

Health Care and Dependent Care Spending Accounts

Plan Document

Effective Date: June 1, 2008

Loyola Marymount University

Plan Document

Loyola Marymount University

Plan Document

Part I. Key Plan Provisions

Plan Sponsor (also the Employer and Plan Administrator)	Loyola Marymount University
Address of Plan Sponsor	One LMU Drive, Suite 1900 Los Angeles, CA 90045
Federal Employer ID #	95-1643334
Plan Number	501
Effective Date of Plan / First Plan Year Start Date	June 1, 2008
First Plan Year End Date	May 31, 2009
Plan Years	June 1 through May 31

Benefits Offered

The following benefits are offered under this Plan:

- Health Care Spending Account (HCSA) – enables pre-tax Employee Contributions toward eligible medical, dental, vision and pharmacy expenses
- Dependent Care Spending Account (DCSA) – enables pre-tax Employee Contributions toward eligible Dependent Care Expenses

Benefit Limits

Minimum and maximum benefits from pre-tax Employee contributions allowed under the Plan per Plan Year. Employer Contributions may be made in addition to these limits.

	Minimum	Maximum
Health Care:	$1.00	$5,000.00
Dependent Care:	$1.00	$5,000.00
Employer Contributions, if any:	Not Applicable	

Eligible Employees

Description of Employees who are eligible to participate in this Plan:

All full-time Employees are eligible to participate on the first of the month following their date of hire.

Access to Benefits

For the Spending Accounts, a Participant may receive benefits using any one of the following methods for each particular incident of expense:

- **Health Care Card** – A Participant can use the Health Care Card to pay for Health Care Expenses directly from his HCSA. The Employee may be required to submit a detailed receipt to show that the card was used for eligible expenses. If the Employee is not able to show the card was used for eligible expenses, the Employee will be required to repay the Plan in the amount of the card transaction. If the Employee fails to repay the Plan, collection of past due amounts will be deducted from future reimbursement checks and/or be subject to other collection policies. Card privileges may be revoked at any time. Use of the card that exceeds the amount elected by the Participant (in accordance with the limits defined under Part I), less amounts previously paid by the Plan for benefits received during the Coverage Period, is the responsibility of the Participant.
- **Pay My Provider** – A Participant can request that payment be made from his HCSA or DCSA and sent directly to the provider indicated by the Participant at the time of request.
- **Pay Me Back Claim** – A Participant can submit a claim by fax or by mail to get paid or reimbursed for out-of-pocket Health Care Expenses or Dependent Care Expenses.

New Hire Enrollment

Are newly hired / newly eligible Employees permitted to enroll during the middle of the Plan Year?	☒ Yes ☐ No
Do newly hired / newly eligible Employees have to satisfy a waiting period?	☒ Yes ☐ No
Once a new hire is eligible, how many days from the first possible coverage date does that eligible participant have to enroll?	30 Days
Does waiting period apply to newly hired / newly eligible Employees during Open Enrollment?	☒ Yes ☐ No

Coverage Effective Date for New Hire Enrollment

☐ Immediately upon satisfying waiting period and requesting enrollment

☒ First of the month following satisfaction of waiting period and requesting enrollment

Qualified Changes

☒ Allowed, per federal guidelines

☐ Not allowed

Number of days following qualified change Employee has to affect enrollment: 31 Days

Coverage Effective Date for Qualified Changes

☐ Immediately upon requesting new enrollment or change in enrollment

☒ First of the month following request of enrollment change (with exception for changes resulting from birth, adoption or placement for adoption – which will be made as of the date of the qualifying event in accordance with HIPAA).

Coverage End Date for Qualified Changes

☐ Immediately upon requesting enrollment cancellation

☒ Last day of the month following request to cancel enrollment

Terminations/Rehires

When a termination is followed by a rehire after any period of time, the requirements for New Hire Enrollment must be satisfied.

Cessation of Participation

An individual will cease to be a Participant in the Plan as the result of any of the following:

- The Plan terminates.
- The Plan Year terminates.
- The Participant ceases to satisfy the eligibility requirements.
- The Administrator determines that the Participant has fraudulently used this Plan to pay for expenses that are not Health Care Expenses or Dependent Care Expenses.
- The Participant terminates from Participation consistent with a Qualifying Event.
- The Participant terminates employment with the Employer (except that Dependent Care Participants may continue to spend down their Dependent Care Account balance with eligible expenses as elected below).

Coverage End Date for Cessation of Participation under the Health Care Spending Account:

☐ **Immediately** ☒ **End of the month**

Coverage End Date for Cessation of Participation under the Dependent Care Spending Account:

☐ Immediately ☒ End of the month ☐ End of the plan year

Mid-Year Claims Deadline

An individual whose coverage ends prior to the end of the Plan Year will have until the end of the month following 3 months after the Plan Year end date to submit claims for reimbursement from the Plan. Claims must be received on this date to be eligible for reimbursement from the Plan.

End-of-Plan Claims Deadline

An individual who is covered through the end of the Plan Year will have until the end of the month following 3 months after the Plan Year end date to submit claims for reimbursement from the Plan. Claims must be received on this date to be eligible for reimbursement from the Plan.

Collecting Premiums During Leave

The following option is offered to Participants:

- Participant can pay with after-tax dollars while on leave.

FSA COBRA Administrator:

Name	WageWorks, Inc.
Street Address	PO Box 991
City, State, Zip	Mequon, WI 53092

Part II. Main Provisions of the Plan

Article I. Introduction

Section 1.01 Purpose of Plan

The purpose of this Plan is to provide Employees of the Employer (as defined under Part I) a choice between cash and payment of Health Care Expenses and Dependent Care Expenses.

Section 1.02 Status

This Plan is intended to qualify as a cafeteria plan (or as part of one) under Code Section 125, an employer-provided health plan (or as part of one) under Code Sections 105 and 106, and/or a dependent care assistance program (or as part of one) under Code Section 129.

Article II. Definitions

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

Section 2.01 Administrator

"Administrator" means the Employer. It shall have the meaning of Plan Administrator as defined in ERISA.

Section 2.02 Affiliated Employer

"Affiliated Employer" means any entity who, within the context of Code Section 414(b), (c), or (m), will be considered with the Employer as a single Employer for Code Section 125 purposes.

Section 2.03 Affiliated Service Provider

"Affiliated Service Provider" means an entity that provides services to WageWorks to complete transactions requested by a Participant, and includes other entities in a chain of service providers.

Section 2.04 Bill Payment Services

"Bill Payment Services" means the service under which the Plan pays Health Care Expenses or Dependent Care Expenses on behalf of a Participant to a provider designated by the Participant. Such services may be provided by WageWorks directly or by one or more of its Affiliated Service Providers.

Section 2.05 COBRA

"COBRA" means continuation coverage under a group health plan under Code Section 4980B and/or ERISA Section 600 et seq.

Section 2.06 Code

"Code" means the Internal Revenue Code of 1986, as amended, and where applicable, the regulations thereunder.

Section 2.07 Coverage Period

"Coverage Period" means for a Participant, the period:

1. Commencing with his Participation or the first day of the Plan Year, whichever is later, and
2. Ending on the termination of Participation or the end of the Plan Year, whichever is earlier.

Section 2.08 Dependent

"Dependent" means a Dependent of a Participant within the meaning of Code §152, as amended and supplemented by IRS Notice 2004-79 and any other subsequent rulings, notices and announcements. For the purpose of Dependent Care Expenses, the term Dependent shall have the meaning given to it by Code Section 129.

Section 2.09 Dependent Care Expenses

"Dependent Care Expenses" means expenses described in Code Section 129, but without regard to any dollar limitations.

Section 2.10 Effective Date

"Effective Date" means the Effective Date of Plan, as defined under Part I.

Section 2.11 Eligible Employee

"Eligible Employee" means an Employee who is determined by the Employer to be eligible to participate in one or more of the benefits under this document. The Employer sets forth the eligibility requirements for this Plan, as defined under Part I.

Section 2.12 Employee

"Employee" means any individual employed by the Employer and treated as an Employee for income and employment tax purposes. An Employee does not include a self-employed individual as described in Code Section 401(c), including partners in a partnership. Further, more-than-2% shareholders in a Subchapter S Corporation are not Employees, nor are the employee-spouse, children, parents, and grandparents of the more-than-2% shareholder in accordance with Code Section 318 attribution rules.

Section 2.13 Employer

"Employer" means the Employer, as defined under Part I.

Section 2.14 Employer Contribution

"Employer Contribution" means the contribution the Employer may provide the Employee toward eligible Health Care or Dependent Care Expenses.

Section 2.15 ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.16 Health Care Card

"Health Care Card" means a card that a Participant may use for expenditures on Health Care Expenses that is accepted by health care service providers that have agreed to accept such cards. The card may not be used for any other purposes.

Section 2.17 Health Care Expenses

"Health Care Expenses" means medical expenses as defined in Code Section 213(d) and under Internal Revenue Code Sections 105(b) and 125 and the regulations thereunder, as modified by Revenue Ruling 2003-102 and any previous or subsequent official pronouncements but without regard to any dollar limitations contained therein. Such expenses may be provided to the Participant, his Spouse, or his Dependents.

Section 2.18 Highly Compensated Employee

"Highly Compensated Employee" means any individual who is defined in Code Section 414(q) and the regulations thereunder.

Section 2.19 HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Section 2.20 Key Employee

"Key Employee" means any individual who is defined in Code Section 416(i)(1) and the regulations thereunder.

Section 2.21 Medical Premiums

"Medical Premiums" means the amount an Eligible Employee must pay to the Employer in order to receive medical, dental, vision, or other health insurance coverage for the Eligible Employee and his Dependents. The actual coverage shall be provided by one or more other plans of the Employer. For the purpose of this definition, the term insurance coverage may include plans that are self-insured in part or in whole, but does not include any HCSA created under this Plan. This Plan merely provides a mechanism for paying Medical Premiums on a pre-tax basis.

Section 2.22 Participant

"Participant" means an Employee who becomes a Participant pursuant to Part 1.

Section 2.23 Plan

"Plan" means the Employer's Plan, offering the benefits defined under Part I, as set forth herein, together with any and all amendments and supplements hereto.

Section 2.24 Plan Year

"Plan Year" means the period beginning on the Effective Date of Plan and ending on the First Plan Year End Date, as defined under Part I, and all subsequent 12-month periods thereafter, unless a short Plan Year (less than 12-months) is the initial Plan Year, the

final Plan Year, or a transition period to a different Plan Year, as indicated in Part I. Notwithstanding the previous sentence, if this Plan is designated as part of another plan subject to Code Section 125, the Plan Year of that other plan shall be treated as the Plan Year for this Plan.

Section 2.25 Qualified Benefits

"Qualified Benefits" means those Qualified Benefits available to a Participant under this Plan. This Plan merely provides a mechanism for paying premiums for Qualified Benefits on a pre-tax basis.

Section 2.26 Spending Account

"Spending Account" means either a HCSA or a DCSA, which the Employer has elected to offer to Eligible Employees as a benefit under this Plan. Each Spending Account is a hypothetical bookkeeping account established by the Employer to track the contributions and the payment of Health Care Expenses and Dependent Care Expenses, as applicable.

Section 2.27 Spouse

"Spouse" means an individual who is legally married to a Participant (and who is treated as a Spouse under the Code), but for purposes of the Dependent Care Savings Account Plan provisions, shall not include an individual legally separated from the Participant under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

Section 2.28 WageWorks

"WageWorks" means WageWorks, Inc., a Delaware Corporation, its successor and assigns. The Administrator has designated WageWorks to provide certain administrative services of the Spending Accounts under this Plan. WageWorks is a Business Associate of the Employer, as the term is defined in HIPAA.

Unless the context requires otherwise, the terms "he," "him," or "his" shall apply to both genders.

The provisions of the Code and the regulations thereunder are incorporated by reference unless otherwise noted.

Article III. Eligibility and Participation

Section 3.01 Eligibility

The Administrator shall determine whether an Employee satisfies the eligibility requirements as defined under Part I. Such determination is final. The Administrator will provide Eligible Employees with enrollment instructions. In order to participate in the Plan, each Eligible Employee must follow the enrollment instructions in the time and manner set out by the Administrator. The provisions of this Section are not intended to override any eligibility requirement(s) or waiting period(s) specified under other Qualified Benefits of the cafeteria plan.

Section 3.02 Plan Year Election

In order to participate, each Eligible Employee must:

1. Make an irrevocable Plan Year election stating the amount of salary to be reduced for Medical Premiums, Health Care Expenses, Dependent Care Expenses, or other Qualified Benefits;
2. Authorize the Employer to reduce his compensation; and
3. Elect the amount of coverage under the benefits options available, subject to the pre-tax maximum defined under Part I.
4. Any amount set aside for Medical Premiums or any other Qualified Benefits shall not be available to pay for Health Care Expenses or Dependent Care Expenses, and vice versa.
5. Any amount set aside for Health Care Expenses shall not be available to pay for Dependent Care Expenses, and vice versa.

An Eligible Employee who fails to make an election, as required by this Section, shall be deemed to have elected to continue the same coverage under the other Qualified Benefits funded by the same election, adjusted to reflect any increase or decrease in premium/cost, then in effect for such Participant or Employee. Notwithstanding the foregoing, annual elections for participation in the Health Care Spending Account and Dependent Care Spending Account must be made by making an election prior to the beginning of each Plan Year.

Section 3.03 Effect of Salary Reduction

An amount equal to the Participant's Plan Year Election shall be deducted from the Participant's wages. The amount so deducted shall become the asset of the Employer. No trust or account will be set aside to hold funds on behalf of the Participant or his beneficiaries.

Section 3.04 Commencement of Participation

Subject to proper enrollment, an Eligible Employee will become a Participant on the later of (a) the Effective Date of the upcoming Plan Year, or (b) the Effective Date defined under Part I, as appropriate given the Participant's date and circumstances of enrollment. Annual enrollments are required to participate in either or both of the Spending Accounts.

Section 3.05 Cessation of Participation

An individual will cease to be a Participant following any of the events described under Part I.

Section 3.06 Reinstatement of Former Participant

A former Participant will become a Participant again if and when the eligibility requirements are satisfied again and, if required by the Administrator, if the Employee reinstates a new salary reduction agreement. Notwithstanding this provision, former Participants who are rehired within 30 days or less of the date of termination of employment may be reinstated with the same election(s) in effect before the termination, if so allowed by the Administrator as indicated in Part I.

Section 3.07 Leaves of Absence

A. Generally

A Participant shall not cease to participate in the Plan merely because he is on a leave of absence. However, in order to maintain coverage, required premiums and contributions, if any, must continue to be paid. Failure to arrange to make required contributions during a leave of absence will be treated as a change in family status and the Participant will be treated as electing no coverage during the leave.

B. FMLA

See Part I for the option(s) offered to the Participant to collect premiums or contributions while an individual is on leave under the Family Medical Leave Act.

C. Uniformed Service Under USERRA

A Participant who is absent from employment with the Employer as a result of "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer within the period prescribed by USERRA. The Participant shall be responsible for making the required premium payments and contributions under the Plan during the period in which he or she is in "uniformed service." The manner in which such premium payments and contributions are made shall be determined by the Administrator, in a manner similar to the above regarding the payment of premiums and contributions with respect to FMLA leave. A Participant whose coverage under the Plan is terminated due to his or her being in "uniformed service," and who is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by the Plan, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

D. Provision for Collecting Premiums During Leave

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (the "FMLA"), to the extent required by the FMLA, the Participant may elect to either revoke or continue health coverage. Such election shall apply consistently to the payment of Medical Premiums and to the HCSA. If the Participant elects to retain coverage during a qualified FMLA leave, the Employer shall first attempt to collect the Participant's share of the contributions by reducing any taxable compensation otherwise payable to the Participant. If the Participant's taxable compensation is not sufficient to cover the contributions owed, the Participant will be offered the option(s) provided under Plan Provisions. Upon return from leave, the Participant may reenter the Plan on the same terms that applied to the Participant prior to taking such leave, or as otherwise required by the FMLA. This section shall be interpreted consistent with the principles of Treasury Regulation at 26 CFR § 1.125-3.

Section 3.08 Family Status and Coverage Changes

As defined under Part I and to the extent not already covered by other sections, the Employer has elected to define those events listed in the Treasury Regulations at 26 CFR § 1.125-4 and any subsequent regulations, rulings or guidance that may affect these regulations as Family Status and Coverage Changes for the Spending Accounts.

For coverage under other Qualified Benefits, the Employer has elected to define those events listed in Treasury Regulations at 26 CFR § 1.125-4 as allowable for election changes, unless otherwise noted in an additional appendix.

For the purpose of Spending Accounts under this Plan, the following events are considered qualified Family Status Changes which would allow a Participant to revoke an existing Plan Year Election and make a new election consistent with this change for the remainder of the Coverage Period:

1. Marital Status Changes – Marriage, divorce, legal separation, death of Spouse, or annulment.
2. Dependent Status Changes – Birth, adoption, or placement for adoption of a child; the death of a child.
3. Employment Status Changes with respect to Employee, Employee's Spouse, or a Dependent, if eligibility is affected – Termination or commencement of employment, strike or lock out, commencement or return from unpaid leave of absence, or change in worksite.
4. Dependent satisfies or ceases to satisfy eligibility requirements due to attainment of age or student status.

For the purpose of the DCSA under this Plan, the following are considered cost or coverage changes which (in addition to the family status changes noted above) would allow a Participant to revoke an existing Plan Year Election and make a new election for the remainder of the Coverage Period:

1. Significant cost or coverage increases or decreases (however, no change is allowed when the cost change is imposed by the dependent care provider who is also a relative).
2. Change in availability of child care provider.

Section 3.09 Election Changes

Notwithstanding the irrevocability of Plan Year Elections under Section 3.02, the Employer has elected to allow changes to Plan Year Election due to Family Status and Coverage Changes under Section 3.08, so long as such changes are consistent with the change in Family Status and/or Coverage. A Participant may submit such request in the time and manner as directed by the Administrator. Such request is subject to the review and approval of the Administrator.

Section 3.10 Medicare and Medicaid

If the Participant, his Spouse, or Dependent who is enrolled in the HCSA or Medical Premiums program under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act, providing for pediatric vaccines), the Participant may cancel the health or accident coverage of the person who becomes entitled to Medicare or Medicaid in a manner similar to an election change (per Section 3.09).

Section 3.11 Continuation Coverage under COBRA

Notwithstanding other provisions, if the Employer provides for Medical Premiums or Health Care Expenses as a benefit option, an individual who ceases to be an Employee may nonetheless continue to participate in that (those) portion(s) of the Plan to the extent monthly contributions, the amount of which shall be determined by the

Administrator, are timely paid to the Employer. All required contributions shall be made in accordance to the procedures established by the Administrator. This Section applies to a Participant only in Plan Years in which the maximum benefits available (as described under Plan Provisions) exceed the required contributions for the Plan Year (or the remainder thereof), and will in no event apply beyond the maximum COBRA coverage period provided by law.

Section 3.12 Certain Judgments, Decrees and Orders

If a judgment, decree or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), the Participant may (a) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage), or (b) change his or her election to revoke coverage for the child (if the Order requires that the former Spouse provide coverage under the former Spouse's plan).

Section 3.13 HIPAA Special Enrollment Rights

If a Participant, a Participant's Spouse, or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Section 9801(f) of the Code, then a Participant may revoke a prior election for group health plan coverage and make a new election (including an election for the HCSA) provided that the election change corresponds with such HIPAA special enrollment rights.

Article IV. Benefits

Section 4.01 Maximum Benefits Available

For Medical Premiums and Other Qualified Benefits – The maximum benefits will be the amount of coverage that could be purchased with premiums elected by the Participant.

For a HCSA – The maximum benefits available at any time during the Coverage Period shall be equal to the amount elected by the Participant (in accordance with the limits, including Employer Contributions, if any, defined under Part I), less amounts previously paid by the Plan for benefits received during the Coverage Period. Any amount credited to the HCSA shall be forfeited by the Participant if it has not been applied toward reimbursement within the run-out period (defined under Part I). Amounts forfeited shall be used to offset administrative expenses or any use that is permitted within the applicable Department of Labor or Internal Revenue Service regulations.

If the Employee terminates employment before the Employer has been reimbursed for the money it has advanced on behalf of the Employee, the entire unreimbursed portion shall be deemed to be an "administrative expense" to be refunded to the Employer by any unused and forfeited HCSA balance(s).

For a DCSA – The maximum benefits available at any time during the Coverage Period shall be equal to the cumulative amount deferred by the Participant (in accordance with the limits defined under Part I), less amounts previously paid by the Plan for benefits received during the Coverage Period. Any amount allocated to the DCSA shall be forfeited by the Participant if it has not been applied toward reimbursement for the Plan Year within the run-out period (defined under Part I). Amounts so forfeited shall be used to offset administrative costs or any use that is permitted within the applicable Internal Revenue Service regulations.

A Participant's exclusion from income for payments under the DCSA in a calendar year is limited to the smallest of the following amounts:

- $5,000 if the Employee is married and filing a joint return or if the Employee is a single parent ($2,500 if the Employee is married but filing separately);
- The Employee's "earned income" for the year; or
- If the Employee is married at the end of the taxable year, the Spouse's earned income.

If the Employee is married but his Spouse is incapable of self-care, and has the same principal place of abode as the Employee for more than half of the year and has no earned income, then the Spouse is deemed to be gainfully employed and to have an "earned income" of $250 per month ($500 per month if there are two or more qualifying individuals) in each month during which he or she is a full-time student or incapable of self-care.

Section 4.02 Methods of Receiving Benefits

Premiums for Qualified Benefits shall be paid by the Employer directly to the Plan provider.

For the Spending Accounts, a Participant may receive benefits using any one of the methods described under Part I for each particular incident of expense.

Section 4.03 Effect of Election Change

If a Participant makes an Election Change under Section 3.09, the maximum benefits under Section 4.01 for the remainder of the Coverage Period will be adjusted accordingly.

Section 4.04 Ineligible Amounts

If the Participant received a benefit (through whatever method) that was not a Health Care Expense or Dependent Care Expense, the Plan will collect from the Participant the amount that was not eligible. If the Participant fails to repay the Plan after reasonable notice, the Plan may seek other remedies, including, but not limited to, any or all of the following: cancellation of the Health Care Card, offsetting of future claims against the erroneous amounts, deduction from the Employee's payroll, and collections through other legal actions.

Section 4.05 Coordination of Benefits Under the HCSA

The HCSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan. However, eligible Health Care Expenses that may be eligible for reimbursement under this HCSA and also a Health Reimbursement Arrangement (HRA) sponsored by the Employer will be processed according to the terms of the HRA Plan Document.

Article V. Administration and Miscellaneous

Section 5.01 Plan Administration

The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in

the Plan without discrimination among them. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

1. To establish and enforce such rules, regulations and procedures as it deems necessary or proper for the efficient administration of the Plan;
2. To interpret the Plan at its full power and discretion, its interpretation to be final and conclusive on all persons claiming benefits under the Plan;
3. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
4. To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan;
5. To provide reports to government agencies as required by Federal and State laws, such as the Code or ERISA; and
6. To allocate and delegate its responsibility under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing.

Section 5.02 Changes by Administrator

If the Administrator determines, before, during, or after the close of any Plan Year, that the Plan may have or actually failed to satisfy any nondiscrimination requirement or any limitation on benefits provided to Highly Compensated Employees or Key Employee imposed by the Code, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or Key Employees without the consent of such Employees, or inclusion of income of discriminatory amounts into such Employees' wages.

Section 5.03 Amendment and Termination of Plan

The Plan may at any time be amended or terminated by the Employer.

Section 5.04 Claims and Review Procedures

1. Claims procedure. Any person may file a claim for a benefit to which the claimant believes he or she is entitled. Such person may file a claim in writing with the Third Party Administrator. If any such claim is wholly or partially denied, the Third Party Administrator will notify such person of its decision in writing. Such notification will be given within 30 days after the claim is received by the Third Party Administrator, or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30 day period. If the denial is due to a failure of the claimant to submit the information necessary to decide the claim, the notice shall specifically describe the required information, and the claimant will be required to resubmit the claim with the required information no later than the claim-it-by date following the end of the Plan Year during which the expenses were incurred. If such notification is not given within such period, the claim will be considered denied as of the last day of such period and such person may request a review of his or her claim.

2. Review procedure. Within 180 days after the date on which a person receives a written notice of a denied claim (or, if applicable, within 180 days after the date on which such denial is considered to have occurred), such person (or his duly authorized representative) may (i) file a written request with the Third Party Administrator for a review of the denied claim and of pertinent documents, and (ii) submit written issues and comments to the Third Party Administrator. The Third Party Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain specific reasons for the decision, as well as specific references to pertinent Plan provisions. The decision on review will be made within 30 days after the request for review is received by the Third Party Administrator. If the decision on review is not made within such period, the claim will be considered denied.

   This decision on review is the Third Party Administrator's final decision. However, should the claimant decide to appeal again, the Employer is the plan fiduciary and as such has the final coverage decision. The claimant has the right to bring a civil action under ERISA Section 502(a) if the final appeal with the Employer is denied following review. Such a suit may be filed only after the plan's appeal procedures have been exhausted.

3. The HCSA shall be subject to claims procedures under ERISA and the regulations thereunder (see 29 CFR Section 2560.503-1 et seq). For the purpose of determining when a claim is made under said regulations, the use of the Spending Card at a health care provider is considered a claim for benefits. However, if the transaction using the Spending Card is declined, it is considered a denial of a claim only if the reason for denial is that the nature of expenditure was either indeterminable or determined not to be an eligible Health Care Expense. Other reasons, such as merchant terminal failures, are not considered a denial of a claim. In either case, the Participant may submit a separate claim for reimbursements for manual adjudication. There are no pre-service claims available under the HCSA.

4. The claims and review procedures for all other medical, dental, vision, or other health plans paid are governed by the respective documents of those plans.

Section 5.05 Nondiscriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

Section 5.06 Examination of Records

The Administrator will make its records under the Plan available to each Participant, as it pertains to the Participant, for examination at reasonable times during normal business hours.

Section 5.07 COBRA and HIPAA Notices

The Administrator shall provide any notices or certification required by COBRA and HIPAA.

Section 5.08 Privacy

Participant, by participation in this Plan, authorizes the transmission of his nonpublic personal information by the Employer, WageWorks, Affiliated Service Providers, and payees to and among each other as a necessary part of the administration of this Plan. No nonpublic personal information of the Participant will be provided to any other third party unless authorized by the Participant. To the extent applicable, the Employer, WageWorks and Affiliated Service Providers will abide by all applicable privacy laws, including but not limited to HIPAA.

Section 5.09 HIPAA Security with Respect to the HCSA

To the extent applicable, the Employer agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information (as defined in 45 CFR Section 160.103) that the Employer creates, receives, maintains or transmits on behalf of the Plan, and to report to the Plan any Security Incidents (as defined in 45 CFR Section 164.304) of which it becomes aware. This Section shall be effective as of April 20, 2005 or such applicable later date as set forth in HIPAA and the applicable regulations issued thereunder.

Section 5.10 Limitation of Rights

The establishment of the Plan or any amendment thereof, the participation and the payment of any benefits shall not be construed as conferring to any individual any legal or equitable right against the Employer, WageWorks, and Affiliated Service Providers.

Section 5.11 Limitation of Liability

WageWorks, the Employer, and the Administrator shall not be responsible for direct, incidental, or any consequential damages due to the failure to make payments on a timely basis.

Section 5.12 Benefits Paid Solely from General Assets

All benefits shall be paid from the general assets of the Employer. No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

Section 5.13 Taxes

No party makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income. Income and Employment taxes are the responsibilities of the Participant and/or the payee. The Employer, WageWorks, or any Affiliated Service Providers shall not be responsible for the reporting, withholding, or payment of taxes to any government agency.

Section 5.14 Nonassignability of Rights

Except with respect to the payee (or its assignee) who provided services described in this Plan to the Participant, the right of any Participant to receive benefits under this Plan shall not be alienable by the Participant by any method to any other creditors, and any attempt to cause such right to be so subjected will not be recognized.

Section 5.15 Tax and Legal Advice

No part of this document or any other documents provided to an eligible Employee may be construed as legal or tax advice. All individuals should seek their own counsel for advice.

Section 5.16 Not an Employment Contract

Neither this Plan, nor any action taken with respect to it, shall confer upon any person the right to continue employment with any Employer.

Section 5.17 Post-Mortem Payments

Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse (still in the name of the Participant), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

Section 5.18 Mental or Physical Incompetency

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator, or other person legally vested with the care of his estate has been appointed.

Section 5.19 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

Section 5.20 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from compensation paid by the Employer.

Section 5.21 Forfeiture of Unclaimed Reimbursement Account Benefits

Any Spending Account benefit payments that are unclaimed (i.e., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

Section 5.22 Governing Law

To the extent not provided by other laws, this Plan shall be construed, administered, and enforced according to the laws of California.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed in its name and behalf this day of , 20 , by its officer there unto duly authorized.

Loyola Marymount University

Signature: _____

Print Name: _____

Title: _____