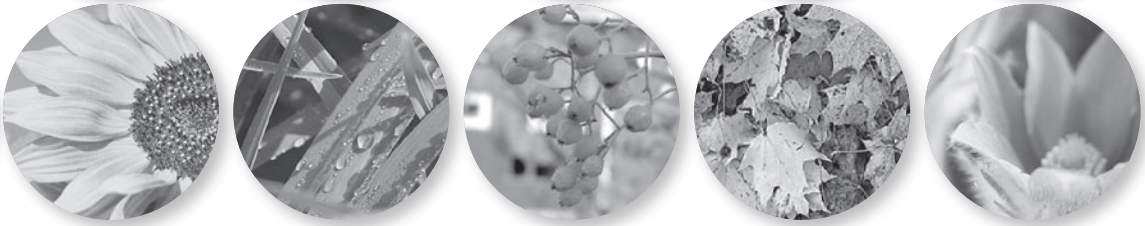
2007 Flexible Benefits Plan



The Research Foundation of State University of New York

Reference Guide

Employee Benefits Resource Directory

The Research Foundation of
State University of New York
Your Campus Benefits Office

Fringe Benefits Management Company
FBMC Customer Service
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

Flexible Spending Accounts
Automated Services
24 hours a day
1-800-865-FBMC (3262)
www.myFBMC.com

Table of Contents

Important Dates to Remember
Your Open Enrollment dates are:
November 1, 2006, through November 30, 2006.

Your Period of Coverage dates are:
January 1, 2007, through December 31, 2007.

Enrollment at a Glance

What's New

- Recent changes to IRS definitions regarding your dependents may affect your Flexible Spending Account (FSA) eligibility and reimbursement. Please refer to the guidelines in the *Health Care FSA* and *Dependent Care FSA* sections of this Reference Guide for more information.
- The maximum deposit limit for the Health Care FSA has increased from $3,000 to $4,000, effective with the 2007 Plan Year.

How the Plan Works

The Research Foundation of State University of New York offers Flexible Spending Accounts (FSAs) to help you reduce your taxes and increase your spendable income. Taking advantage of the plan is simple; just select the Flexible Spending Account(s) you need – Health Care Flexible Spending Account (HCFSA), Dependent Care Flexible Spending Account (DCFSA) or both.

You authorize per-pay-period deposits to your FSA from your before-tax salary. When you incur eligible health care or dependent care expenses, you request tax-free withdrawals from your account to reimburse yourself. You never have to pay federal and state income, or Social Security taxes on the money you contribute to your FSA. Since you pay less in taxes, you have more spendable income.

If you are joining during Open Enrollment, your Enrollment Form must be submitted by November 30, 2006, in order to participate during the next plan year (January 1, 2007, through December 31, 2007).

Important Enrollment Information

- An IRS Revenue Notice permits a "grace period" of two months and 15 days following the end of your 2007 Plan Year (December 31, 2007) for a Health Care FSA. This grace period ends on March 15, 2008. Funds will be automatically deducted from any remaining dollars in your 2007 Health Care FSA balance.
  You should not confuse the grace period with the plan's "run-out period." The run-out period extends until March 31, 2008. This is a period for filing claims incurred anytime during the 2007 Plan Year, as well as claims incurred during the grace period mentioned above.
- Your Dependent Care FSA also has a "run-out period" that extends until March 31, 2008. However, the "grace period" mentioned above **does not** apply to this account. You may not submit reimbursement requests for expenses that occur after December 31, 2007.
- Open Enrollment is November 1, 2006, through November 30, 2006.
- Your 2007 Plan Year is January 1, 2007, through December 31, 2007.
- To join at another time of year, you **must** fill out an Enrollment Form when you first become eligible.
- **If you do not complete a form, you will not be enrolled in FSAs.**
- Return your completed Enrollment Form to your benefits office.
- For more information, contact Fringe Benefits Management Company (FBMC) Customer Service by calling 1-800-342-8017, Monday - Friday, 7 a.m. - 10 p.m. ET.

Making Your Benefits Work for You — It's Easy.

- Once you review the FSA guidelines and become familiar with how the program works, you'll determine how the program can save you and your family a significant amount of tax money — if you're clear on the governing IRS rules. See Page 5 for FSA guidelines.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) to FBMC for reimbursement processing. Once the plan year ends, you have until March 31, 2007 to submit your supporting documentation.
- You may visit FBMC's Web site at **www.myFBMC.com** or call FBMC Customer Service at 1-800-342-8017.

Flexible Spending Accounts

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax-free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes and
- security of paying anticipated expenses with your FSA.

Is an FSA right for me?

If you spend $130 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at **www.myFBMC.com/customer/taxanalysis.asp**.

What types of FSAs are available?

Your employer offers you a Health Care FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Health Care FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Health Care FSA, including:

- prescription and health care copays
- eyeglasses beyond Vision Plan limits
- orthodontia and dental care beyond Dental Plan limits
- Over-the-Counter items.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- daycare services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the *Health Care FSA* and *Dependent Care FSA* sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account 48 hours after claim approval.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Direct Deposit Enrollment Form available from your **Benefits Office**, visit **www.myFBMC.com** or call FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four and six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Service.

- Visit **www.myFBMC.com**.
- Call 1-800-342-8017 (Monday - Friday, 7 a.m.-10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Flexible Spending Accounts
Continued

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA. Refer to the "Written Certification" portion of the *Beyond Your Benefits* section of this Reference Guide for more specifics.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
3. The IRS permits a "**grace period**" of two months and 15 days following the end of your 2007 Plan Year (December 31, 2007) for a Health Care FSA. This grace period ends on March 15, 2008. **During this grace period, you may incur eligible medical expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2007 Health Care FSA.
4. **The grace period mentioned above does NOT apply to Dependent Care FSAs.**
5. You have a run-out period (until March 31, 2008) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2007 Plan Year. For Health Care FSAs only there is a new "grace period," which extends until March 15, 2008. Please see the FSA Grace Period information box on this page for details.
6. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
7. You cannot deduct reimbursed expenses for income tax purposes.
8. You may not be reimbursed for a service which you have not yet received.
9. Be conservative when estimating your medical and/or dependent care expenses for the 2007 Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year.
10. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
    - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
    - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
    - I will not seek reimbursement through any additional source and
    - I will collect and maintain sufficient documentation to validate the foregoing.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Health Care or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, **www.myFBMC.com**, or call FBMC Customer Service at 1-800-342-8017. For more information, refer to the *Getting Answers* section of this Reference Guide.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information.

FSA Grace Period

An IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2007 Plan Year (December 31, 2007) for a Medical Expense FSA. This grace period ends on March 15, 2008. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2007 Medical Expense FSA.

You should not confuse the grace period with the plan's "**run-out period**." The run-out period extends until March 31, 2008. This is a period for filing claims incurred anytime during the 2007 Plan Year, as well as claims incurred during the grace period mentioned above.

Your Dependent Care FSA also has a "run-out period" that extends until March 31, 2008. However, the "grace period" mentioned above does not apply to this account. You may not submit reimbursement requests for expenses that occur after December 31, 2007 against the 2007 Plan Year.

Claims will be processed in the order in which they are received by FBMC, and your accounts will be debited accordingly. If you have funds remaining in an account for the prior plan year, these funds will be used first until exhausted. Then, subsequent claims will be debited from your new plan year account balance.

Eligibility Requirements

Who is Eligible?

Health Care Flexible Spending Account (HCFSA)

Research Foundation employees are eligible if they:

- are employed on a salaried basis
- receive regular, biweekly paychecks
- are scheduled to work at least 50 percent of the time on a regular appointment (.50 FTE)
- have completed six months of service from date of hire and
- are expected to be employed for at least one year following the date of enrollment or re-enrollment.

Ineligible employees include:

- summer-only appointments
- hourly employees
- full-time employees of the State University of New York
- full-time students of the State University of New York who are employed as a Project Instructional Assistant, Research Project Assistant, Research Aide, Research Graduate Assistant or Senior Research Aide, Camp Counselor-Student and
- an individual engaged by the Research Foundation as an independent contractor, regardless of any retroactive reclassification of such individual as a common-law Research Foundation employee for any purpose.

Newly eligible employees must enroll within 60 days of the date they meet all eligibility requirements; otherwise they must wait until the next Open Enrollment period (unless there is a qualifying event). Enrollment during a subsequent Open Enrollment period may not take place unless all eligibility requirements are still being met at the time of enrollment. Upon certain qualifying events, a covered employee, their spouse and dependents may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For additional information, refer to the COBRA Q&A section beginning on Page 15.

Dependent Care Spending Account (DCFSA)

Research Foundation employees are eligible if they are employed on a salaried basis and receive regular, biweekly paychecks. There is no waiting period.

Ineligible employees include:

- hourly employees
- full-time students of the State University of New York who are employed as a Project Instructional Assistant, Research Project Assistant, Research Aide, Research Graduate Assistant or Senior Research Aide, Camp Counselor-Student and
- an individual engaged by the Research Foundation as an independent contractor, regardless of any retroactive reclassification of such individual as a common-law Research Foundation employee for any purpose.

Newly eligible employees must enroll within 60 days of their date of hire; otherwise they must wait until the next Open Enrollment period (unless there is a qualifying event). Enrollment during a subsequent Open Enrollment period may not take place unless all eligibility requirements are still being met at the time of enrollment.

Employees on Leave

If you are on paid leave of absence, your pre-tax contributions will continue. If your approved leave falls under the Family and Medical Leave Act (FMLA), talk to your Campus Benefits Office about your rights and obligations. Refer to the Changing Your Coverage section beginning on Page 13 for more information.

If your leave does not fall under FMLA and is not paid leave, you must have a COBRA-qualifying event in order to continue participating in the HCFSA. See COBRA Q&A on Page 15 for further instructions.

DCFSA Note: Amounts that you pay for dependent care services while you are not working because of illness, are not eligible for reimbursement. This rule applies even if you receive sick pay and continue to be considered as an employee.

HCFSA Note: Any HCFSA services incurred after your period of coverage terminates may not be eligible for reimbursement unless you apply for continuation under COBRA through FBMC, the Contract Administrator. Monthly after-tax COBRA premiums will include your contribution, plus a two percent add-on administrative fee. Refer to the COBRA Q&A section on Page 15 for more information.

Terminating Employees

Dependent Care Flexible Spending Account–A DCFSA is not continuable upon termination of employment; however, you can continue to request reimbursement for eligible expenses incurred until you exhaust your account balance or the plan year ends.

Note: IRS requirements for an eligible expense under this benefit is that your spouse must be working, and you must be actively at work at the Research Foundation at the time the expense is incurred.

Health Care Flexible Spending Account– Except as provided by COBRA (see Page 15), reimbursement for health care expenses is only allowed after termination of employment if the expenses were incurred prior to your termination at the Research Foundation.

Termination and Re-hire During Same Plan Year–Unless otherwise provided by law or your employer's HCFSA Plan, if you terminate your employment and are re-hired during the same plan year:

- within 30 days or less from the date of your termination, you will automatically be reinstated into the FSA annual elections you had prior to termination (with access to your HCFSA balance up to the full annual limit, reduced by prior submitted and approved reimbursements, for eligible health care expenses incurred after your return to work). Missed deductions will be made up.
- after 30 days or more from the date of your termination, you will automatically be reinstated into the FSA salary reduction levels you had prior to termination, and the annual benefit maximum will be pro-rated based on the remaining number of payroll periods in the year. Missed deductions will not be made up.

Getting Answers

Getting answers to many of your benefit questions is now easier than ever. FBMC Customer Service offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response system or Customer Service.

FBMC Web Site

FBMC's Web site provides information regarding your benefits and comprehensive details on your FSAs.

By entering **www.myFBMC.com** into your Internet browser, you will open FBMC's home page. Answers to many of your benefit questions can be obtained by using the navigational tabs located along the top portion of the home page. You'll be prompted to enter your Social Security number (SSN) and Personal Identification Number (PIN). After this login, you can access the following benefit information.

Benefits

You may check your benefit status, read benefit descriptions, check out our tax calculator and much more.

Claims

Not only can you check the status of your claim, but you may also download forms, get more information about mailing and faxing your claim to FBMC or see transactions that need documentation.

Accounts

View your account balance and contributions. You may also view monthly statements and review your transaction history.

Profile

Change the e-mail address we have on file, complete your online registration or select a new PIN.

Resources

Peruse our extensive resource library, including benefit materials, surveys, Over-the-Counter drug listings and benefit tips.

Forms

Download applicable forms for claim submission and reimbursement.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN, whether using the Web site or the IVR system. After your initial login, you will be asked to register and select your own confidential PIN to access both systems in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record PIN here.
Remember, this will be your PIN for both Web and IVR access.

If you forget your PIN, click the "Need Help?" link for help or you may call Customer Service at **1-800-342-8017**.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

Health Care FSA

Minimum Deposit: **$5 per pay period**
Maximum Annual Deposit: **$4,000 Annually**

What is a Health Care FSA?

A Health Care FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Your Health Care FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child** if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year
- is 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- has not provided more than one-half of his or her own support during the taxable year (nor received more than one-half of their support from you during the taxable year if a full-time student age 19 through 23 at the end of the taxable year).

An individual is a **qualifying relative** if he or she is a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire taxable year and receives more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if he or she is physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Health Care FSA.

When are my funds available?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Health Care FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Health Care FSA. Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers. For a more comprehensive list of eligible OTC items, please visit **www.myFBMC.com**.

*Partial List of Medically Necessary Eligible Expenses**

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Health Care FSA
Continued

You may be reimbursed for OTCs through your Health Care FSA if:
- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Health Care FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at **www.myFBMC.com**. As soon as an OTC item, medicine or drug becomes eligible under any of the categories, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Health Care FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Can travel expenses for medical care be reimbursed?
Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Health Care FSA. With proper substantiation, eligible expenses can include:
- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

Is orthodontic treatment reimbursable?
Orthodontic treatment designed to treat a specific medical condition is reimbursable through your Health Care FSA if the proper documentation is provided:
- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?
With a Health Care FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax-free, regardless of the amount. By enrolling in a Health Care FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?
Expenses not eligible for reimbursement through your Health Care FSA include:
- insurance premiums
- expenses covered by insurance
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?
You may use your Health Care FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?
Requesting reimbursement from your Health Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:
- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

Please note that cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are NOT valid documentation for Health Care FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

* EOBs are not required if your coverage is through a HMO.

Dependent Care FSA

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for **qualifying individuals**.

A qualifying individual includes a **qualifying child**, if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year
- is 12 years old or younger and
- has not provided more than one-half of his or her own support during the taxable year.

A qualifying individual includes your **spouse**, if he or she:

- is physically and/or mentally incapable of self-care
- lives in your household for more than half of the taxable year and
- spends at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative**, if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- is physically and/or mentally incapable of self-care
- is not someone else's qualifying child
- lives in your household for more than half of the taxable year and
- spend sat least eight hours per day in your home and
- receives more than one-half of their support from you during the taxable year.

Note: If you are the tax dependent of another person, you cannot claim qualifying individuals for yourself. You cannot claim a qualifying individual if he or she file a joint tax return with their spouse. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Minimum Deposit: **$5 per pay period**
Maximum Annual Deposit: **The maximum contribution depends on your tax filing status as the list below indicates.**

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Health Care FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Partial List of Eligible Expenses*

After school care
Baby-sitting fees
Daycare services
In-home care/au pair services
Nursery and preschool
Summer day camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Dependent Care FSA
Continued

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information. You may also visit www.myFBMC.com to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement. Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are NOT valid documentation for Dependent Care FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Health Care FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL	$ _____
DIVIDE by the number of paychecks you will receive during the plan year (26).*	
This is your pay period contribution.	$ _____

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Daycare services	$_____
In-home care/au pair services	$_____
Nursery and preschool	$_____
After school care	$_____
Summer day camps	$_____

ELDER CARE SERVICES

Daycare center	$_____
In-home care	$_____
TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year.	$_____
DIVIDE by the number of paychecks you will receive during the plan year (26).*	
This is your pay period contribution.	$_____

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. FBMC will in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **60 days** of an event that is consistent with one of the events on the following page, you must complete and submit a Change in Status/Election Form to FBMC. Contact FBMC to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by FBMC, unless otherwise provided by law. If your FSA election change request is denied, you will have **60 days**, from the date you receive the denial, to file an appeal with FBMC. For more information, refer to the "Appeal Process" at the end of this section.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility–** If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan–** If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses–** You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Appeal Process

If you have a request for a mid-plan year election change, FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to **FBMC**.

Your appeal must state:

- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon request of it and its supporting documentation. You wil be notified of the results of this review within 30 business days from the receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within the regulations governing the plan.

Changing Your Coverage
Continued

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Health Care FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Health Care FSA plan. † Does not apply to a Dependent Care FSA plan.

COBRA Q&A

Important Continuation Coverage Information

What is continuation coverage?

Federal law requires that most group health plans, including Health Care Flexible Spending Accounts (Health Care FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. "Qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from your employer.

How long will continuation coverage last?

For Group Health Plans (Except Health Care FSAs):

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

For Health Care FSAs:

If you fund your Health Care FSA entirely, you may continue your Health Care FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Health Care FSA for the year. For example, if you elected a Health Care FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year or until such time that you receive the maximum Health Care FSA benefit of $1,000.

If your employer funds all or any portion of your Health Care FSA, you may be eligible to continue your Health Care FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Health Care FSAs. If you have questions about your employer-funded Health Care FSA, you should call Fringe Benefits Management Company (FBMC) at 1-800-342-8017.

How can you extend the length of continuation coverage?

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify FBMC of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation coverage and qualify will be entitled to the 11-month disability extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify FBMC of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify FBMC within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends

COBRA Q&A
Continued

because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Health Care FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days after the date of your election.** (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month**. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and FBMC.

Can you elect other health coverage besides continuation coverage?

If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact FBMC if you wish to elect alternative coverage.

If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For More Information

This *COBRA Q&A* section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from The Research Foundation of State University of New York.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **www.dol.gov/ebsa**.

The Fine Print

Terms and Conditions

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between your employer and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Spending Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Service at 1-800-342-8017 for an approximation.

FBMC Privacy Notice ***4/14/03***

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

The Fine Print
Continued

III.We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

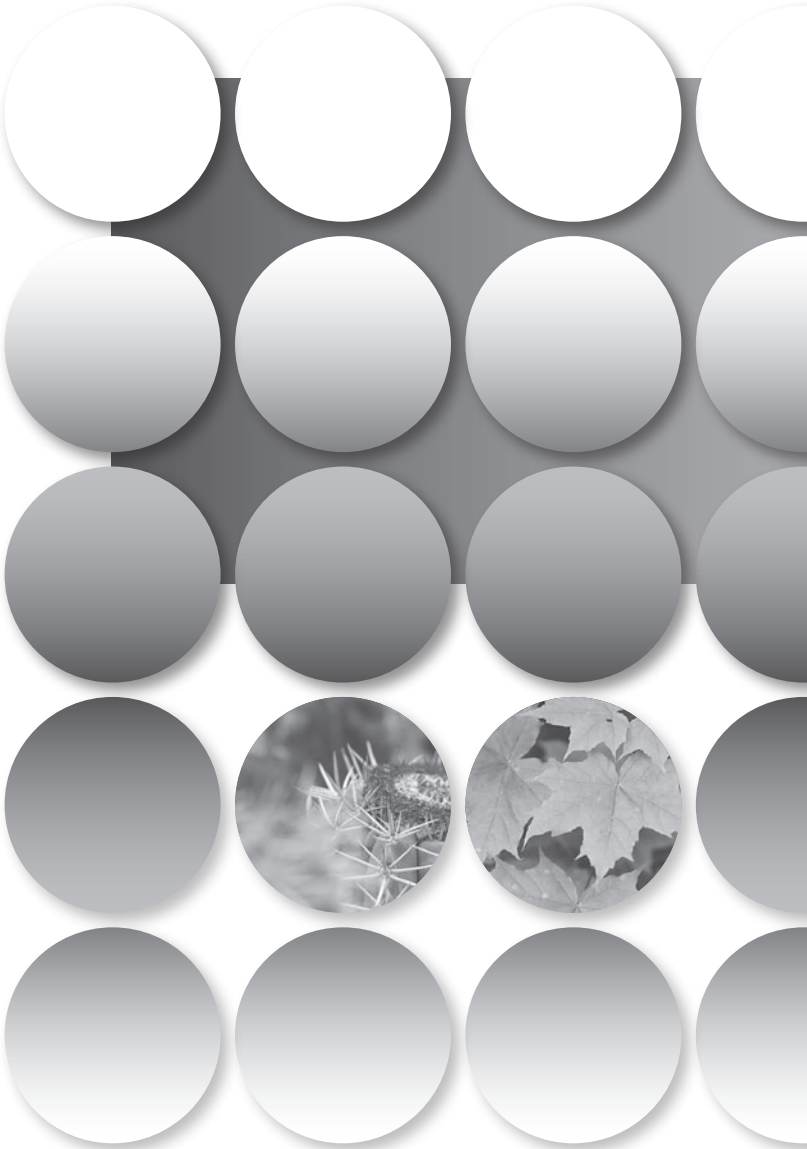
We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Notes



FBMC

proven benefit solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Service 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/SUNY/0806