
**LOYOLA UNIVERSITY MARYLAND
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION**

Summary Plan Description

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A. INTRODUCTION

Your Employer offers this Flexible Benefits Plan as part of its employee benefits program. This Plan is intended to qualify under Section 125 of the Internal Revenue Code so that you can take advantage of the tax-free benefits offered by your Employer, as described in this Summary Plan Description.

By paying your share of the cost of your elected benefits as a reduction to your compensation under a Salary Reduction Agreement, your contribution will not be subject to Federal income, Social Security or Unemployment taxation, in most cases State income taxes, and can result in a net increase in spendable income. The Employer pays its portion of the costs for your elected benefits, if any, out of its general assets.

By entering a Salary Reduction Agreement, your benefit costs are reduced as illustrated by the following example:

| | With Your Plan | Without Your Plan |
|------------------------|-----------------------|--------------------------|
| Gross Taxable Wages | \$25,000. | \$25,000. |
| Pre-tax Contribution | \$1,800. | N/A |
| Taxable Wages | \$23,200. | \$25,000. |
| Estimated Taxes* | \$3,480. | \$3,750. |
| After-tax Contribution | N/A | \$1,800. |
| Take-home Pay | \$19,720. | \$19,450. |

* Joint Return, 15% marginal tax rate

By paying for benefits before taxes are calculated, estimated taxes are reduced by \$270, which is \$22.50 per month more in take-home pay for our example person. In other words, paying for benefits without entering a Salary Reduction Agreement would cost this person \$22.50 more per month. You should consult a tax advisor for a more accurate estimate for your situation.

This Summary Plan Description is a brief description of the Plan and your rights, benefits and obligations under the Plan. This Summary Plan Description is not meant to interpret, extend or change any provisions contained in the Plan Documents maintained by the Employer. The provisions of this Flexible Benefits Plan can only be accurately understood by reading the Plan Document(s). The Plan Documents are on file with the Employer and may be requested by you, your covered dependents, or your legal representative by contacting the Benefits Coordinator. These rights are described in Section G. of this Summary Plan Description.

B. GENERAL INFORMATION

You may need the following information if you have any questions about your Plan.

1. GENERAL PLAN INFORMATION

Your Employer maintains Plan Documents as required for the general welfare plans that are offered to Employees. Your rights to request and review these documents are described under Section G.

The name of your Employer's Plan is the Loyola University Maryland Flexible Benefits Plan.

Your Employer has included this Plan under Plan Number 510.

The provisions of this Plan are effective on July 1, 2012. The Employer's Flexible Benefits Plan has been in effect since July 1, 1985.

Plan records are maintained on a 12-month period known as the Plan Year. The Plan Year for this Flexible Benefits Plan is July 1st through June 30th.

This Flexible Benefits Plan that allows you to reduce your taxable income by your contribution to the cost of your elected benefits, and any fringe benefit plan offered by your Employer, is governed by the Internal Revenue Service (IRS) Code and not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

However, any general welfare plans sponsored by your Employer are subject to ERISA. Some of your basic rights under ERISA are described in this Summary Plan Description. For a complete description of your rights under ERISA and other federal and state law as related to the general welfare plans sponsored by your Employer you should consult the Summary Plan Descriptions that are maintained by your Employer for these Plans.

2. EMPLOYER INFORMATION

The name, address and tax identification number of the Employer are:

Loyola University Maryland
4501 North Charles Street, Suite 3200
Baltimore, MD 21210
410-617-1366

EIN Number (Tax ID) 52-0591623

3. PLAN ADMINISTRATOR INFORMATION

The name, address and telephone number of your Plan Administrator is:

Loyola University Maryland
4501 North Charles Street, Suite 3200
Baltimore, MD 21210
410-617-1366

Your Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine at its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan.

4. BENEFITS COORDINATOR

Director of Benefits has been named as the Plan's Benefits Coordinator.

5. LEGAL REPRESENTATIVE

The following person has been named your Plan's agent for service of legal process:

Loyola University Maryland
4501 North Charles Street, Suite 3200
Baltimore, MD 21210

Service of process can also be made upon the Plan Administrator.

6. MISCELLANEOUS PROVISIONS

Termination and Amendment of Plan

The Employer expects to maintain the Plan indefinitely as an employee benefit. However, the Employer has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Employer, the Plan automatically will terminate unless it is continued by the successor to the Employer.

Participants in the Plan have no Plan benefits after a Plan termination or a partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial termination and except as otherwise expressly provided, in writing, by the Employer.

No Continued Employment

No provisions of the Plan or this Summary shall give any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

Non-Assignment Of Benefits

Except as may be required pursuant to a "Qualified Medical Child Support Order" which provides for Plan coverage for an alternate recipient, other applicable law, or electronic payment made directly to a health care provider, no Participant or beneficiary may transfer, assign or pledge any Plan benefits.

Excess Payments

Upon any benefit payment made in error under the Plan, the Employer will inform you that you are required to repay the amount that has been paid under this Plan in error. This includes and is not limited to amounts over your annual election, amounts for services that are determined not to be qualified expenses, or when you do not provide adequate documentation to substantiate a paid claim upon request. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and reducing the amount of future benefit reimbursements by the amount paid in error.

C. PARTICIPATION

Each Eligible Employee is eligible to participate in the Plan the first day of the month following or coincident to their date of hire, or the first day of the month following the month in which the Employee otherwise becomes eligible to participate as defined in this Summary Plan Description or by applicable law, so long as the Employee is employed by the Employer on the day they are enrolled.

The various benefit plans offered by your Employer may have different plan years. For instance, an Employer may enter into an annual contract with an insurance company to provide benefits to its Employees that has a contract year that is different from the Plan Year established for this Flexible Benefits Plan. If this is the case, you will have different benefit entry dates for each of these benefit plans.

Employees who fall into the following groups are excluded from participating in the Plan:

- (1) Part-Time Employees who work less than 22.5 hours per week;
- (2) Employees who are non-resident aliens and receive no earned income from the employer which constitutes income from sources within the United States;
- (3) Employees covered by a collective bargaining plan; and,
- (4) Employees who are self-employed individuals as described in section 401(c) of the Internal Revenue Code including sole proprietors, partners in a partnership or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

If you are not eligible to participate in this Plan and are allowed to continue to participate under any benefit plan offered by your Employer, under the eligibility terms of that Plan, then your cost will be paid with taxable income, and your compensation will not be reduced by the Employer.

If you become eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for Accident or Health Benefit coverage sponsored by the Employer you will be allowed to participate in this Plan, so long as you comply with the provisions set out in HIPAA. See your Plan Administrator for details.

ENROLLMENT

Upon becoming eligible to Participate in this Plan, an Employee that is enrolled in a Qualified Benefit Plan will be deemed to have executed a Salary Reduction Agreement that authorizes the Employer to reduce the Participant's Compensation in the amount necessary to fund the Employee's share of the cost of the Qualified Benefits Plans. For any Plan Year, an Employee has the right to decline coverage and refuse salary reduction by submitting a written request to the Benefits Coordinator.

For any following Plan Year, the Qualified Benefits Plans under which you are enrolled will be in effect for the new Plan Year. You will be deemed to have executed a valid Salary Reduction Agreement for the amount necessary to fund your share of the cost of the Qualified Benefits Plans.

You are required to execute a Salary Reduction Agreement to participate in the Reimbursement Plans offered by your Employer. You are also required to execute a Salary Reduction Agreement if you are electing to make a tax free contribution to a Health Savings Account under your Employer's 125 Plan. If you do not execute a Salary Reduction Agreement before the start of any new Plan Year, you will not be allowed to enroll or participate in the Reimbursement Plans described in this Summary Plan Description for the new Plan Year. If you want to participate in the Reimbursement Plans for any new Plan Year, you

must inform the Plan Administrator in writing of your intent to participate, the Plan that you elect, and your annual election that will be reduced from your salary or wages on a pre-taxed basis.

Requesting Limited Coverage under your Medical Reimbursement Plan When Your Spouse Enrolls in an HSA that is not arranged by your Employer.

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning December 31, 2003. In order to sign up for a Health Savings Account, an individual cannot be covered under this Medical Reimbursement Plan. If your Spouse contributes to an HSA, or contributions are made to an HSA on behalf of your Spouse, then claims for services rendered for your Spouse (and Dependents if covered by the HSA) cannot be reimbursed under this Medical Reimbursement Plan. In order to allow your Spouse to contribute to an HSA Account, you are required to submit a written request to your Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Medical Reimbursement Plan. Qualified Expenses will be limited to covered services or supplies provided to you or your dependents that are not covered under the HSA. No claims for family members covered under the HSA can be submitted under this Plan. If a written request for limited coverage is not received then you will be enrolled in family coverage which will reimburse you for Qualified Expenses rendered for your Spouse and Dependents.

CHANGING YOUR ELECTIONS/CHANGE IN STATUS

The laws governing Flexible Benefits Plans generally do not allow you to change your benefit and contribution elections during a Plan Year. There are exceptions to this rule. You may change your benefit and contribution elections if you experience a "change in status" when the change you request is consistent with the change in status. Please note that you can make a prospective change to a Health Savings Account election under this Plan at any time during the Plan Year without having a change in status.

For the purpose of changing your premium contribution election outside of a scheduled open enrollment period to pay your share of the premium required for coverage under a Qualified Benefit Plan on a tax preferred basis, a "change in your status" means: a change in your legal marital status (events that change your legal marital status include marriage; death of spouse; divorce; legal separation; and annulment); the adoption, birth, or death of a child or Dependent; the emancipation or coming of age of a child so that the child is no longer eligible as a Dependent under the Plan; the employment of you or your Spouse; change in your residence; the beginning or end adoption proceedings; automatic changes upon cost increases or decreases; significant cost increases; significant curtailment of coverage; addition or elimination of similar benefit package option allowing (prohibiting) employees that previously opted out of other benefits to make an election change; change in coverage under an employer plan of a spouse or dependent; FMLA leaves; the exercise of HIPAA special enrollment rights; a COBRA qualifying event; a judgment, decree or order requiring coverage for a spouse or child; the open enrollment period for another qualified plan offered by the Employer, or; Medicare or Medicaid entitlement.

These changes are limited when applied to the Medical Reimbursement Plan. A "change in status" for a Medical Reimbursement Plan is limited to: a change in your legal marital status (events that change your legal marital status include marriage; death of spouse; divorce; legal separation; and annulment); the adoption, birth, or death of a child or Dependent; the emancipation or coming of age of a child so that the child is no longer eligible as a Dependent under the Plan; the employment of you or your Spouse; the beginning or ending adoption proceedings, or; Medicare or Medicaid entitlement. For the Medical Reimbursement Plan, you will not be allowed to reduce your contributions below the amount you have already been reimbursed during the current Plan Year.

You need to submit any request for changes to your elections within 30 days of any applicable event.

You (or your estate) will not be required to make further contributions to the Plan once you have died, retired, terminated employment, or have a change in job status so that you are no longer eligible to participate under this Plan.

Note that the new benefit elections can start only after your change in status has taken place and the new form has been filed. For example, assume that you have a change in status from the list above. You could request a change in your benefits ahead of time to be effective on the date of the event. However, making other unrelated changes that are not consistent with the event or changes that are effective before the date of the event would not be approved.

You may be required to increase your contribution if the Plan's cost for a particular benefit should increase during the Plan Year. If, for example, premiums for health insurance offered under the Plan are raised during the year, you will be required to pay your share of the increased cost. Your election and payroll deduction will automatically change to cover the change in premium. If the change in cost is considered a "significant cost increase" under the change in status rules you will be allowed to change your benefit elections with 30 days notice.

An Employee who is eligible, but not enrolled, for coverage under the terms of an Employer sponsored group health plan (or a Dependent of the Employee if the Dependent is eligible, but not enrolled for coverage under the Employer sponsored group health) can enroll for coverage under the Employer sponsored group health and make the appropriate salary reduction election under this Flexible Benefits Plan to fund the Employee's portion of the cost of the coverage if either of the following conditions are met:

(1) TERMINATION OF MEDICAID OR SCHIP COVERAGE;

The Employee or Dependent was covered under a Medicaid plan or under a State Child Health Plan (SCHIP).

The coverage of the Employee or Dependent under the Medicaid or SCHIP plans is terminated as a result of loss of eligibility.

The Employee requests coverage under the group health plan not later than 60 days after the date of termination of the Medicaid or SCHIP coverage; or,

(2) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR SCHIP;

The Employee or Dependent becomes eligible for assistance, with respect to coverage under the group health plan from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

The Employee requests coverage under the group health plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

The term group health plan as used in this paragraph does not include the Medical Flexible Spending Account funded by employee contributions.

ENDING PLAN PARTICIPATION AND LEAVES OF ABSENCE

Because you contribute to this plan on a pre-tax basis, you must be receiving pay from your employer in order to make those contributions. Usually, your participation in the plan will end when you stop making pre-tax contributions. The rest of this section explains the rules regarding suspending or ending your participation in the plan.

Each Participant will be enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment, or until the earlier of when the:

(1) Participant dies, resigns or terminates employment with the Employer;

(2) Participant fails to make required contributions under the Plan;

- (3) Participant ceases to be an Employee;
- (4) Plan terminates; or,
- (5) Participant revokes their election under a Change In Status.

If you go on a leave of absence because of military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). You will be required to pay for coverage in an amount allowed under USERRA. This extension of coverage will end on the earlier of: (1) the last day of the 24-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Your Employer can provide additional information if necessary.

ENDING PLAN PARTICIPATION

A Participant whose employment terminates and is subsequently re-employed within 30 days of their separation of service and within the same Plan Year will immediately rejoin the Plan with the same Benefit elections.

Should the Participant return within 30 days of their separation of service during the following Plan Year, the Participant will be allowed to change elections through the Open Enrollment process.

A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy Plan eligibility requirements to rejoin the Plan. Any unused reimbursement Benefits Accounts balance prior to the initial separation of service date will be forfeited.

CONTINUING PLAN PARTICIPATION UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA"), continuation shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 Employees on a typical business day during the preceding calendar year. This Summary Plan Description describes rights under COBRA for Medical Reimbursement Plan Participants. Your rights under any of the Qualified Benefits Plans offered by your Employer are described in the Summary Plan Description for that Plan and can be obtained from your Benefits Coordinator.

If you elect to participate under the Medical Reimbursement Plan and are considered a Participant on the day before experiencing a qualifying event, you are only eligible to continue the Medical Reimbursement Plan under COBRA until the end of the current Plan Year. If on the day of your qualifying event, the amount of your annual election less any claims that have been reimbursed is less than the amount of premium required to continue the Medical Reimbursement Plan until the end of the Plan Year, then COBRA continuation coverage will not be offered.

A Participant who experiences a qualifying event is considered qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage to send the COBRA Election Notice. A qualified beneficiary has the responsibility to notify the Plan Administrator of their desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Keep in mind, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.

Listed below are qualifying events.

- (1) Termination of employment (for reason other than "gross misconduct");

- (2) Reduction of employee's work hours.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer can require the COBRA payments be apportioned for the remainder of the Plan Year.

THE FAMILY AND MEDICAL LEAVE ACT ('THE FMLA')

The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances that are prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave for group health plans are:

- (1) Pre-pay. Under this option, you will pay your share of premium payments that will be due during your leave, before your FMLA leave begins. The payments may be either pre-tax or after-tax, according to the terms of your Salary Reduction Agreement.
- (2) Pay-as-you-go. Under this option, you will pay your share of premium payments on the same schedule as if you were not on leave, or under another schedule according to Department of Labor regulations. If you fail to make payments under this Pay-as-you-go option, your Employer is not required to continue coverage. However, if your Employer chooses to continue coverage, your employer is entitled to collect these amounts from you after you return from the FMLA leave.
- (3) Catch-up-option. Under this payment option your Employer will advance your share of the group health premiums while you are on FMLA leave. Your Employer will be entitled to recover such advanced amounts when you return from FMLA leave.

If a Participant's coverage under the Plan ceased while on FMLA leave, the Participant will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Participant will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Participant can continue with the amount withheld from the Participant's compensation on payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

D. FUNDING

INTRODUCTION

This Flexible Benefit Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This lowers your federal and state taxes.

There are two types of benefit plans offered by your Employer that can be funded under this Flexible Benefits Plan by your salary reduction, premium benefits and reimbursement benefits.

Premium benefits are the actual payments made to secure your participation in insurance plans. These are payments made from the general assets of your employer to an insurance company.

Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

PAYMENT OF PLAN EXPENSES

The cost of the plan includes administrative expenses and the amount paid to provide benefits such as premium payments to insurance companies and reimbursement benefits. The amount needed to provide your benefits depends on your benefit elections. You and your Employer share in the cost of your benefits under your Plan. The Employer pays its portion from the general assets and you pay your portion through salary (or wage) reductions.

LIMITATIONS ON YOUR CONTRIBUTIONS

The maximum contribution you can make to this Plan is an amount equal to your costs for purchasing all of the most expensive benefit plans offered by your Employer, plus the maximum amount you are allowed to defer under the terms of any reimbursement-type programs offered by your Employer.

EMPLOYER CONTRIBUTIONS/SPENDING CREDITS

Your Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefit Plan, or used in a limited manner as defined by your Employer. Your Employer may make defined contributions to specific Qualified Benefit Plans. The enrollment materials used each Plan Year include the amount of any Employer contributions, the rules defining how the Employer contributions can be used by Participants, include all limitations on the use of Employer contributions, and are incorporated into this SPD by reference. Employer contributions will continue to be provided while on approved FMLA leave to the same extent provided to an Employee actively at work.

E. BENEFITS

Benefit Determinations are made in accordance with the terms of the Plan Documents and where appropriate the Plan provisions are applied consistently with respect to similarly situated Employees.

PREMIUM BENEFITS

Your Employer will pay the premium or required contribution for the benefit plans you have elected out of its general assets. This Flexible Benefits Plan is provided to allow you to pay your share of the costs for the benefit plans, if any, offered by your Employer that you selected on a pre-tax basis through an agreement with your Employer to reduce your salary or wages in the amount necessary to pay your share of the cost of your elections. For example, if you elected coverage under a health plan offered by your Employer, and your Employer requires you to pay a portion of the premium, your salary or wages will be reduced to cover your share of the costs, and the Employer will pay the premium for the insurance plan out of its general assets.

You can pay some COBRA premium for plans offered by this Employer. You must have taxable salary from the Employer that can be reduced to pay the COBRA premium (such as severance payments). The COBRA premium has to be for the Employee, spouse or tax dependent for health care purposes. Examples: COBRA premium for a loss of dependent status could be paid on a pre-tax basis for a child that has not reached the age of 27 in the calendar year in which the premium is paid. COBRA premium for a divorced spouse cannot be pre-taxed because the divorced spouse is not claimed on the Employee's federal tax return. The coverage under COBRA must be for months that are within the current Plan Year, COBRA premium for months that are not within the current plan year for this Plan cannot be paid.

The Employer intends that this Plan will comply with the non-discrimination requirements described in the IRS Code. Generally, this means in qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate based on compensation, status, ownership or position with the Employer.

The following qualified benefit plans are offered by the Employer and can be funded under this Flexible Benefits Plan. You should refer to the Summary Plan Description or other Plan Descriptions that are available from your Employer for detail regarding the coverage provided under these plans, the cost sharing term such as deductibles and copayments, limitations and exclusions, and if applicable your rights under ERISA. You can request a copy of these descriptive materials from the Benefits Coordinator.

Health Plan

Dental Plan

Vision Plan

Short Term Disability Plan

Group Term Life Insurance: NOTE – the cost of excess coverage as determined in Table I, published by the IRS, will be imputed income. Excess coverage is any amount over a \$50,000 benefit.

REIMBURSEMENT PROGRAMS

Your Flexible Benefits Plan allows you to direct some of your salary (or wage) reduction so that this money can later be returned to you, tax free, to pay for certain allowed expenses, called qualified expenses.

In order for an expense to be eligible for reimbursement it must be "qualified", as explained below. It must also be incurred during the period of coverage (usually the plan year). This means that you must have

received services, such as having seen the doctor or had a child in day care, on a date during the period in which you are covered by the applicable reimbursement plan.

Assume that your enrollment is effective as of March 1. If you saw the doctor on February 28, that expense would not be eligible for reimbursement, even if you received an invoice dated after March 1.

If your participation in the reimbursement program ends, for any reason, any expenses incurred after that date are ineligible for reimbursement. If you have not incurred expenses equal to the amount of your annual election BEFORE that date, you forfeit the unused amount.

ONCE YOU HAVE ELECTED TO DEFER MONEY TO ONE OF THE PROGRAMS BELOW, YOU CANNOT CHANGE THAT ELECTION, SUBJECT TO THE EXCEPTION REGARDING A CHANGE IN STATUS. ANY MONEY LEFT OVER AT THE END OF THE PLAN YEAR IN THESE PROGRAMS BECOMES THE PROPERTY OF THE EMPLOYER.

A PARTICIPANT WHO IS COVERED ON THE LAST DAY OF ANY PLAN YEAR CAN SUBMIT ELIGIBLE CLAIMS UP TO THE LAST DAY OF THE FOURTH MONTH FOLLOWING THE END OF THE PLAN YEAR.

IF YOU TERMINATE PARTICIPATION IN THE REIMBURSEMENT PLAN(S) PRIOR TO THE LAST DAY OF THE PLAN YEAR, FOR INSTANCE YOU LEAVE EMPLOYMENT AND ARE NO LONGER ELIGIBLE, THEN YOU WILL HAVE 120 DAYS FROM THE LAST DATE OF PARTICIPATION TO SUBMIT CLAIMS. CLAIMS MUST BE FOR SERVICES PROVIDED DURING YOUR PERIOD OF COVERAGE. CLAIMS FOR SERVICES AFTER YOUR TERMINATION ARE NOT ELIGIBLE.

THE MEDICAL REIMBURSEMENT PLAN

Money directed into the Medical Reimbursement Program will be returned to you, tax free, to pay for any qualified medical expenses that are not covered by medical insurance or any other benefit program. The maximum amount you may defer to this program is \$2500 per Plan Year, not to exceed any calendar year salary reduction limit established by federal law. This amount is available on each day of the Plan Year for services rendered on a day that you are a covered Participant.

In order to qualify for tax free treatment, the only medical expenses that will be reimbursed under this Plan are those that satisfy the IRS Code Section 105 reimbursement requirements. The expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, with certain limitations described under Services Not Covered; (b) incurred by an Employee who has made a valid pre-tax election to participate in the Plan, such Employee's Spouse, or tax dependent for health care purposes as defined in Section 105(b), and (c) not otherwise taken as a medical deduction by a taxpayer.

Qualified expenses under the Medical Reimbursement Program are medical expenses that are not covered under any other benefit program. Thus, co-payments, deductibles, certain excluded services, expenses for prescriptions or medical supplies that are not paid for by insurance can be considered expenses that can be reimbursed under your Medical Reimbursement Program.

Examples of expenses eligible for reimbursement under this Program would include: hospitalization and clinical care; prescription and over the counter drugs; transportation expenses (such as an ambulance) incurred to get medical services; home improvement costs that are recommended by a doctor and necessary for treatment or rehabilitation only to the extent such improvement does not increase the value of your home. You can obtain a complete list of covered services at no charge by contacting your Benefits Coordinator.

A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under new federal law, an over-the-counter medicine obtained on or after January 1, 2011 can only be reimbursed tax free if a Participant obtains and submits a Prescription with their claim for

reimbursement. A Participant must submit a ' Prescription' that meets all state law requirements of the state in which the Prescription was written. The person who wrote the Prescription must be allowed to prescribe drugs under applicable state law. A Medicine is any over the counter item that the IRS determines is purchased for the primary purpose of applying the drug or biological contained in the item.

Insulin will continue to be reimbursed without a Prescription.

SERVICES NOT COVERED. The following examples would usually not qualify as expenses eligible for reimbursement even though recommended by a doctor: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for the general well being of a Participant; items that would have been purchased by a Participant even if the Participant did not have a medical condition such as a toothbrush; vacation and travel expenses even if for rehabilitation or prescribed by a doctor; and, long term care expenses that are not for actual medical care; stockpiling over the counter items in quantities that could not reasonably be used during the current Plan Year.

The Plan is required to reimburse you for claims for a qualified benefit you incur while a Participant, up to the maximum you elected, at any time during the Plan Year. For example, assume that you have elected to establish a Medical Reimbursement account of \$600 for the Plan Year, \$50 each month. During the first month when there is only \$50 in your account, you have qualified medical expenses of \$300. The Plan must reimburse you the full \$300 and take the risk that you might terminate employment before the full \$300 has been contributed.

A Qualified Medical Expense can only be reimbursed under your Medical Reimbursement Plan when a claim is submitted to your Plan Administrator or Service Provider, as identified on your reimbursement claims form. If you do not already have claims forms, they can be obtained from your Plan Administrator. Your claims must include a written statement from your medical provider that a medical expense has been incurred and the amount of the expense, and a written statement from you that the medical expense has not been reimbursed and is not reimbursable under any other health plan coverage.

The Plan Administrator will determine whether the claim is covered under the Plan within 30 days of receipt of the claim for reimbursement. In addition to the items described above, the Plan Administrator will require proper evidence of the following:

- (1) the name of the person or persons for whom the expenses have been incurred;
- (2) the nature of the expenses incurred;
- (3) the date the expenses were incurred; and
- (4) the amount of the requested reimbursement.

Each claim for benefits must be accompanied by a third party statement that substantiates these required items, or by automated means that comply with guidelines established by the IRS. If your claims can be submitted electronically, you will be required to sign a certification upon enrollment or acceptance of an electronic card that among other things certifies that claims submitted under the card have not been reimbursed or are not reimbursable under any other health plan coverage.

You are required to repay the Plan in the amount of any claim that has been paid to you in error. This includes and is not limited to amounts over your annual election, amounts for services that are determined not to be Qualified Expenses, or when you do not provide adequate documentation to substantiate a claim that was paid by electronic means. The Employer may take reasonable steps to recoup such an amount including reducing the amount of future benefit reimbursements by the amount paid in error.

GRACE PERIOD. The Medical Reimbursement Plan allows reimbursement for Qualified Expenses, when the services are rendered during the grace period. The grace period extends two and one half months

after the last day of your Plan Year. The last day of this grace period is the fifteenth day of the third month following the end of the Plan Year. Services that are rendered after the last day of this grace period will not be considered for reimbursement under the prior Plan Year.

You must be enrolled on the last day of the Plan Year in order for this grace period to apply.

Order of payment. Medical services that qualify for reimbursement and are rendered during the grace period will be reimbursed using any remaining amount in your prior Plan Year annual election first, and then reimbursed from any new Plan Year annual election.

Participants who terminate before the end of the Plan Year. If you terminate coverage under the Medical Reimbursement Plan for any reason prior to the last day of the Plan Year, then you will not be able to submit any claims for services that were rendered after your date of termination. The grace period rules described above will not be available.

THE DEPENDENT CARE ASSISTANCE PLAN

The Dependent Care Assistance Plan is a separate written plan of an Employer for the exclusive benefit of the Employees, to provide the Employees with dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to their employment.

Qualified expenses under the Dependent Care Assistance Program include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are only provided to the extent of your payroll deduction on the date that the claim is processed.

All child and dependent care expenses must be for the care of one or more Qualifying Persons. A Qualifying Person is:

- (1) A child whom is claimed as the Participant's Dependent and who was under the age of 13 when the care was provided:
- (2) A Participant's Spouse who was physically or mentally not able to care for himself or herself and lived with the Participant for more than half of the year;
- (3) A person who was physically or mentally not able to care for himself or herself and lived with the Participant for more than half of the year, and either:
 - (a) Was the Participant's Dependent:
 - (b) Would have been the Participant's Dependent except that:
 - i) He or she received gross income equal to or in excess of the exemption amount for dependents under Internal Revenue Code § 151(d):
 - ii) He or she filed a joint return;
 - iii) The Participant, or the Participant's spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents: Even if a Participant cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if:

- (1) The child was under the age of 13 or was physically or mentally not able to care for himself or herself;

(2) The Participant was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and

(3) The non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents.

If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Before deciding to participate in the Dependent Care Assistance Program, you should know that there is a provision in the Federal Income Tax Code that allows you to take a credit against taxes for Dependent Care Assistance Expenses. Internal Revenue Code Section 21 allows taxpayers to take a credit against tax of up to \$3000 per qualified dependent (up to a maximum of \$6000 per year) for dependent care assistance expenses. This allowable tax credit may be more advantageous for any lower-paid Participants in this Plan. The Plan Administrator or Benefits Coordinator will be glad to discuss whether participating in this Program or taking the tax credit under Internal Revenue Code Section 21 would be better for you.

Also, the tax laws further limit how much you can contribute to this Program. Under the law and the terms of the Plan, you can defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or \$5000 per year to this Program. A married Participant who files separate tax returns is limited to \$2500 per year. If you also participate in the Loyola University Maryland Child Care Voucher Program, these maximum amounts include both the Dependent Care Assistance program and the Child Care Voucher program. Please consult your professional tax advisor to determine the optimal use of dependent care offerings.

Generally, you can't receive reimbursements under this Program if you are married and your spouse doesn't work (unless your spouse is a full-time student or unable to work, then your spouse is deemed to have a monthly income of \$250, if you have one dependent, \$500 if you have two or more dependents).

You can only apply for reimbursement for household service expenses, including payments to baby-sitters, maids, nurses and cooks who work in your house, to the extent their services are for the care of a qualified individual. Household service expenses would not include payments to a gardener or chauffeur.

Out-of-home expenses would include payments for well-being and protection of qualified individuals. This would include nursery school, day-care centers, and certain summer camp expenses. This does not include expenses for educational expenses for children in kindergarten or beyond, or food, clothing and transportation expenses unless provided by the day care provider to and from the place where the care is provided.

In order to qualify as a day care center, the center must care for more than six individuals who do not live on the premises, and comply with all applicable state and local laws.

Out-of-home care expenses for your spouse or dependents over the age of 12 who are unable to care for themselves qualify under this Program only if those individuals regularly spend at least eight hours each day in your home. Therefore, nursing home expenses do not qualify under this Program. However, in-house expenses for these individuals would qualify.

You cannot receive reimbursement for dependent care services provided BY your child under the age of 19, even if that child is providing you with otherwise-qualified dependent care assistance.

The law requires that you give the name, address and taxpayer identification number for any person or organization that you use for dependent care assistance on your tax return. If you fail to get this information from any party who provided dependent care assistance to you, you will have to include any amounts you paid through reimbursement under the Dependent Care Assistance Program (or had paid directly by the Dependent Assistance Program) to that party in your gross income for the year. Thus, it is very important that you get this information as soon as possible from those parties providing dependent

care assistance to you or your family. It is your responsibility to get this information. The Plan Administrator will not be liable for any additional taxable income to you that might have been avoided if the proper information had been furnished.

Upon any benefit payment made in error, the Plan Administrator will inform you that you are required to repay the amount that has been paid under this Plan in error. This includes and is not limited to amounts over your annual election, amounts for services that are determined not to be Qualified Expenses, or when you do not provide adequate documentation to substantiate a paid claim upon request. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and reducing the amount of future benefit reimbursements by the amount paid in error.

BENEFITS DUE TO A MEDICAL CHILD SUPPORT ORDER

The Plan Administrator will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

- (1) relates to the provision of child support related to health benefits for a child of a Participant of a group health plan
- (2) is made pursuant to a state domestic relations law and
- (3) which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan Administrator will promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within 30 days of receipt of a medical child support order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party will be treated as a claimant and the claims procedure of the Plan will be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

A Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO will not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93). Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

F. DENIED ELECTIONS REQUESTS AND CLAIMS DENIALS

The Plan Administrator is responsible for the administration of the welfare benefit plans sponsored by your Employer. The duties of the Plan Administrator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan. Subject to applicable State or Federal law, any interpretation of any provision of this Plan made in good faith by the Plan Administrator and any determination by the Plan Administrator as to any Participant's rights or benefits under this Plan is final, shall be binding upon the parties and shall be upheld on review, unless it is shown that such interpretation or determination was an abuse of discretion (*i.e.*, arbitrary and capricious). Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

The Benefits Coordinator is responsible for the administration of the Flexible Benefits Plan, the Dependent Care Assistance Plan, and other fringe benefit plans sponsored by your Employer that are not considered general welfare plans. The duties of the Benefits Coordinator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan.

ELECTION REQUESTS

After becoming a participant in the Plan, file all change requests with the Benefits Coordinator. The Benefits Coordinator will determine, in accordance with the various laws that apply to Flexible Benefits Plans, whether or not to grant your requests.

If a request for a benefit election change is denied or participation under the Plan is not allowed by the Employer or designee of the Employer, and you do not agree with the decision, you should contact the Benefits Coordinator. Upon request, the Benefits Coordinator will furnish you in writing the reasons for the denial. In most cases, the written denial will be provided to you within 30 days of the date the denied request or the date the enrollment form was received by the Employer. The written denial will refer to the Plan provision, or section of the IRS Code which was relied upon in making the decision. The Benefits Coordinator may request additional information to properly make a determination. The Benefits Coordinator will review any documentation or written material submitted by you or your representative.

CLAIMS FOR REIMBURSEMENTS UNDER THE DEPENDENT CARE ASSISTANCE PLAN

When you submit a claim for reimbursement under the Dependent Care Assistance Plan described in this Summary Plan Description, the Benefits Coordinator will notify you of an adverse benefit determination no later than 30 days after receipt of the claim. This period may be extended by the Benefits Coordinator when the Benefits Coordinator determines that such an extension is necessary. If an extension is necessary due to your failure to submit the information necessary to determine if the claim can be reimbursed, the notice of extension will specifically describe the required information necessary to process the claim.

After the claim has been denied, you will be allowed an opportunity to appeal. If requested in writing, and within 180 days of the claim denial, the Benefits Coordinator will review the appeal within 60 days of the request for review of the denied claim, the Benefits Coordinator will notify you in writing of the final decision. You can submit written comments, documents, records, and other information relating to the claim with your appeal. You can request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether the information was submitted or considered in the initial denial.

CLAIMS FOR REIMBURSEMENTS UNDER THE MEDICAL REIMBURSEMENT PLAN

When you submit a claim for reimbursement under the Medical Reimbursement Plan described in this Summary Plan Description, the Plan Administrator will notify you of an adverse benefit determination no later than 30 days after receipt of the claim. This period may be extended one time by the Plan Administrator for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be allowed 45 days from receipt of the notice within which to provide the specified information.

The denial notice you receive will state the reason(s) for the denial and refer to the Plan provision or section of the Internal Revenue Code upon which the Plan Administrator relied in making the decision to deny the claim. The denial notice will include a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary. It will describe the review procedures and the time limits applicable to such procedures, and include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will include the specific rule, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

Your authorized representative can act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan Administrator has established reasonable procedures for determining whether an individual has been authorized to act on your behalf. There are no fees charged to appeal a denial of a claim for reimbursement.

After the claim has been denied, you will be allowed an opportunity to appeal. If requested in writing, and within 180 days of the claim denial, the Plan Administrator will give you a full and fair review within 60 days of the request for review of the denied claim, the Plan Administrator will notify you in writing of the final decision. The decision to deny reimbursement will be reviewed in a manner that does not afford deference to the initial denial and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the denial nor the subordinate of such individual. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim. You can request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether the information was submitted or considered in the initial denial.

You may, however, feel that you were treated unfairly. The Employee Retirement Income Security Act of 1974 (ERISA) provides all plan participants with certain rights. If you feel the Plan Administrator violated these rights, you may be able to take legal action in a court of law. Generally, this type of action can be taken only if you can prove that the Plan Administrator did not act in accordance with the terms of your Plan, or that the Plan Administrator acted in bad faith when making its decision. You must first file an appeal within the time limits stated in Part F, with the Plan Administrator, in order to bring a lawsuit in federal court for an item that can be appealed under this Plan. Filing an appeal will have no effect on any other claim submitted under any welfare benefit plan sponsored by your Employer.

CLAIMS UNDER OTHER PLANS

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

G. STATEMENT OF ERISA RIGHTS

As a Participant in any Plan that is subject to Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections under ERISA. In general, the welfare benefit plans sponsored by your Employer such as but not limited to the Medical Reimbursement Plan are subject to ERISA. Fringe benefit plans such as but not limited to Premium Conversion Plans and the Dependent Care Spending Accounts are not subject to ERISA.

ERISA provides that you are entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan Sponsor, the Plan Sponsor's address.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the ERISA Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this Summary Plan Description and the documents governing the ERISA Plan on the rules governing your COBRA continuation coverage rights.

RECEIVE CREDIT AGAINST PRE-EXISTING CONDITIONS LIMITATIONS

ERISA provides that you are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. NOTE: This credit right does not apply to the Medical Reimbursement Plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an ERISA Plan. The people who operate an ERISA plan, called "fiduciaries" have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for an ERISA Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

You must first file an appeal within the time limits stated in Part F, with the Plan Administrator, in order to bring a lawsuit in federal court for an item that can be appealed under this Plan.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your ERISA Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.