

# **Hawaii Residency Program**

## **CAFETERIA PLAN**

### **SUMMARY PLAN DESCRIPTION**

**As Adopted Effective: August 1, 2002**  
**Amended & Restated: August 1, 2003**  
**Amended & Restated: August 1, 2004**

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**HAWAII RESIDENCY PROGRAM  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION**

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**HAWAII RESIDENCY PROGRAM  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION (“SPD”)**

HAWAII RESIDENCY PROGRAM (the “Employer”) is pleased to sponsor an employee benefit program known as a “Flexible Benefits Plan” (the “Plan”) for you and your fellow employees. It is so-called because it lets you choose from several different employee benefit plans (which we refer to as “Benefit Package Options”) according to your individual needs, and allows you to use pretax dollars to pay for them by entering into a salary reduction arrangement with the Employer. This Plan helps you because the benefits you elect are nontaxable (i.e. you save social security and income taxes on the amount of your salary reduction). Alternatively, to the extent described in your enrollment materials, you may choose to pay for any of the available benefits with after-tax contributions as deductions from your salary.

Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this SPD. You will be referred to the Plan Information Appendix throughout the SPD.

In some cases, the Employer may adopt Health and/or Dependent Care Spending Accounts. If so, they will be listed as “Benefit Package Options” offered under the Plan and the SPD for each Spending Account adopted by the Employer will be attached to this SPD as an Appendix.

This SPD and the attached Appendices (collectively, the SPD) describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

**HAWAII RESIDENCY PROGRAM  
Flexible Benefits Plan  
SUMMARY PLAN DESCRIPTION**

**Cafeteria Plan SPD**

**PART I: Questions & Answers**

**Q-1. What is the purpose of the Plan?**

The purpose of the Plan is to allow eligible employees to pay for certain benefits called “Benefit Package Options” with pretax dollars called “Pretax Contributions”. The Benefit Package Options that may be paid for with Pretax Contributions under the Plan (Pretax Contributions as described in more detail in Q-5 of this Part 1) are listed in the Plan Information Appendix.

**Q-2. Who can participate in the Plan?**

Each employee of the Employer (or an Affiliated employer listed in the Plan Information Appendix) who satisfies the Plan Eligibility requirements set forth in the Plan Information Appendix “Eligibility Requirements” and who is eligible to participate in any of the Benefit Package Options offered under the Plan, will be eligible to participate in this Plan as of the eligibility date set forth in the Plan Information Appendix “Eligibility Date”. Those employees who actually participate in the Plan are called “Participants.”

The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Package Options offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Package Options, please refer to the plan summary of each of the Benefit Package Options. If you do not have summaries for each of the Benefit Package Options, you should ask the Plan Administrator of each Benefit Package Option for copies.

**Q-3. How do I become a participant?**

You become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an “Election Form”) on which you agree to pay for the Benefit Package Options that you choose with Pretax Contributions. You will be provided with a Salary Reduction Agreement or Election Form on or before your eligibility date described in the Plan Information Appendix. You must complete the form and submit it to the Plan Administrator or its designated third party administrator (as indicated on the Salary Reduction Agreement), during one of the election periods described in Q-6 below. You cannot become a participant in this Plan prior to the date you complete the Salary Reduction Agreement and submit it to the appropriate person(s).

The effective date of coverage under the Benefit Package Options will be effective as set forth in the governing documents for the component Benefit Package Options. You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of personal identification number (“PIN”) and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan

administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

**Q-4. When does my participation in the Plan end?**

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-7 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Appendix; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or you or the class of employees of which you are a member is specifically excluded from the Plan.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will *automatically* cease, and you will not be able to make any more Pretax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g. a severance arrangement where the individual is permitted to continue a Benefit Package Option on a pretax basis out of severance pay). If you are rehired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year.

**Q-5. What tax advantages are available through the Plan?**

Suppose your monthly gross pay is \$2,500 per month and your cost for coverage is \$140 per month. Also, suppose your total federal withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$1,794. However, under the pretax premium plan you will be considered to have received \$2,360 gross pay rather than \$2,500 for tax purposes with \$140 contributed for medical coverage. This means your take home pay will be \$1,825 with the pretax premium plan rather than \$1,794 without it. Thus, you save \$31 per month (\$372 per year) by participating in the pretax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	\$2,500	\$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	<u>2,360</u>	<u>2,500</u>
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-Tax Coverage	<u>--</u>	<u>140</u>
Take Home Pay	1,825	1,794

**Monthly Savings:      \$31**

**Q-6. What are the election periods for entering the Plan?**

When you are first hired, you must enroll during the “Initial Election Period” described in the Plan Information Appendix or the enrollment material in order to become a Participant in the Plan. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated third party administrator). The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a change in status event described in Q-7 below.

If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year; however, you may nevertheless be covered by certain Benefit Package Options automatically. These automatic Benefit Package Options are called “Default Benefits” and are identified in the enrollment material that you receive. Your share of the contribution for such Default Benefits may be automatically withdrawn from your pay on a pretax basis. If there are no Default Benefits, then you will have no coverage under the Benefit Package Options offered under this Plan if you fail to make an election under this Plan.

The Plan also has an “Annual Election Period” during which you may enroll (if you did not enroll during the Initial Election Period), continue your previous election or change your previous elections for the next Plan Year. The Annual Election Period will be identified in the Plan Information Appendix or the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a change in status event described in Q-7 below.

If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue participation in the Plan with the same Benefit Package Option elections that you had on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an “Evergreen Election”. Alternatively, the Plan Administrator may deem you have to elect not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The consequences of failing to make an election during the Annual Election Period will be described in the enrollment material that you receive.

If the employer adopts a Health Care Spending Account and/or Dependent Care Spending Account, you must make an election each Annual Election Period in order to participate in either the Health Care or Dependent Care Spending Accounts during the next Plan Year. Evergreen Elections do not apply to the Health Care Spending Account and Dependent Care Spending Account.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

**Q-7. Can I ever change my election during the Plan Year?**

Generally, you cannot change your election to participate in the Plan or vary the Pretax Contribution and/or Non-elective Contribution allocated thereto by you (if applicable) for Benefit Package Options you

have elected during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections for Pretax Contributions only during the Annual Election Period, and then, only for the coming Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator within election change period set forth in the Plan Information Appendix following the events described below:

**1. Change in Status.** If one or more of the following “Changes in Status” occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse)
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent)
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit. NOTE: the rules governing election changes when you take a leave of absence are described in Q-12 of this SPD.
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student)
- a change in your, your Spouse’s or your Dependent’s place of residence

If a Change in Status occurs, you must inform the Plan Administrator (or its designated third party administrator) and complete a new election form within the Change of Election Period set forth in the Plan Information Appendix “Change of Election Period”.

If you wish to change your election based on a Change in Status, the election must be on account of and correspond with the Change in Status event as determined by the Plan Administrator (or its designated third party administrator). With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects coverage eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which type of election changes that are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal

separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, there are instances in which you may be able to increase your Pretax Contributions to pay for COBRA coverage of a dependent. Contact the Plan Administrator (or its designated third party administrator) for more information.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit package option) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care Spending Account (if offered under the Plan).* (See the list of Benefit Package Options offered under the Plan in the Plan Information Appendix). With respect to the Dependent Care Spending Account, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent Care Spending Account program as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care expenses for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent Care Spending Account. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent Care Spending Account would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan).* (See the list of Benefit Package Options offered under the Plan in the Plan Information Appendix). For group term life insurance, disability income and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

**2. Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a Benefit Package Option that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

**3. Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

**4. Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

**5. Change in Cost.** If you are notified that the *cost* of your Benefit Package Option coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Package Option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, your Pretax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to the Health Care Spending Account to the extent offered under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

**6. Change in Coverage.** If you are notified that your Benefit Package Option coverage under the Plan is *significantly curtailed*, you may revoke your election and elect coverage under another Benefit Package Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or *significantly improves* a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the plan year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above “Change in Coverage” exceptions are applicable to the Health Care Spending Account, to the extent offered under the Plan.)

Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

**Q-8. How are my contributions under the Benefit Package Option(s) made?**

When you become a Participant, your share of the contributions for the elected Benefit Package Option(s) will be paid with Pretax Contributions that you have elected to make on the Salary Reduction Agreement or Election Form. Pretax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted. In addition, all or a portion of the cost of the Benefit Package Options may, in the Employer’s discretion, be paid with contributions made by the Employer on behalf of each Participant these are called (“Non-elective Contributions”). The amount of the Non-elective Contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer’s sole discretion. The Non-elective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the employer deems relevant. In no event will any Non-elective Contribution be disbursed to you in the form of additional taxable compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may provide you with Non-elective contributions and then allow you to allocate the Non-elective Contributions among the various Benefit Package Options that you choose (subject to restrictions described in the enrollment material).

**Q-9. How long will the Plan remain in effect?**

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

**Q-10. What happens if my claim for benefits under this Plan is denied?**

If you are denied a benefit under the Plan (e.g. election changes, eligibility for pretax benefits), you will generally proceed in accordance with the following claims review procedures.

**Step 1:** *Notice of Denial is received from third party administrator.* If your claim is denied, you will receive written notice from the third party administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the third party administrator, the third party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2:** *Review your notice carefully.* Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

- a. the reason(s) for the denial and the Plan provisions on which the denial is based;
- b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- d. a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the third party administrator, you may file a written appeal. You will need to file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you may file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you may file your appeal with the third party administrator. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you will need to submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

**Step 4:** *Second Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the Plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the third party administrator. Otherwise, the second notice of denial will be sent no later than 60 days after the Plan Administrator has received the appeal.

**Step 5:** *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

**Step 6 (if there is a second level of appeal as indicated in the notice of denial):** *If you still disagree with the third party administrator's decision, file a 2<sup>nd</sup> Level Appeal with the Plan Administrator.* If you still do not agree with the third party administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the third party

administrator. You will need to gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your 2<sup>nd</sup> Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

**Q-11. What effect will Plan participation have on Social Security and other benefits?**

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation.

**Q-12. What happens if I take a leave of absence?**

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pretax Contributions if that is what was used before the FMLA leave began).
- (c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave on a Pretax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pretax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.
- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from an unpaid non-FMLA leave.
- (g) If you go on an unpaid non-FMLA leave of absence (e.g. personal leave, sick leave, etc) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Q-7 of this Part I will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

## **PART II: Other Important Information about the Cafeteria Plan**

Participation in the Plan does not give any participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan.

The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix attached to this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information has been provided in the Plan Information Appendix attached to this SPD.

**HAWAII RESIDENCY PROGRAM  
Flexible Benefits Plan  
SUMMARY PLAN DESCRIPTION**

**APPENDIX I – Health Care Spending Account SPD**

**General Information about the Health Care Spending Account**

You will have the opportunity to elect to receive income tax-free reimbursement (“Health Care Reimbursements”) for some or all of your unreimbursed health care expenses (“Eligible Medical Expenses”) under the Health Care Spending Account (“HCSA”). Under the HCSA, you may purchase a specific level of Health Care Reimbursement benefits, paying for coverage with Pretax Contributions.

**Part I: Questions & Answers**

**Q-1. Who can participate in the Health Care Spending Account?**

Each employee of the Employer (or an Affiliated employer listed in the Plan Information Appendix) who satisfies the HCSA eligibility requirements set forth in the Plan Information Appendix “HCSA Eligibility Requirements” is eligible to participate in the HCSA as of the eligibility date set forth in the Plan Information Appendix “HCSA Eligibility Date”.

**Q-2. How do I become a Participant?**

You become a participant in the HCSA by electing a specific level of Health Care Reimbursement benefits during the Initial or Annual Election Periods. (The Initial and Annual Election Periods are described in Q-6 of Part I of the Cafeteria Plan SPD). Your participation in the HCSA will be effective on the date that you make an election or your HCSA Eligibility Date. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-7 of Part I of the Cafeteria Plan SPD. You must make an election during the Annual Election Period in order to participate during the next Plan Year. Evergreen elections described in Q-6 of Part I of the Cafeteria Plan SPD do not apply.

Once you become a Participant, you may also receive reimbursements for Eligible Medical Expenses incurred by your “Eligible Dependents”. For purposes of the HCSA, eligible dependents include your legal spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and any other individuals who would qualify as a tax dependent under Code Section 152 for purposes of your federal income tax return.

If the Plan Administrator receives a qualified medical child support order relating to the Health Care Spending Account, the HCSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients

(or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your HCSA (See Q-3 below), you will be notified in writing, and after receiving the order, you will be informed of the determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

**Q-3. What is my Health Care Spending Account?**

If you elect benefits under this portion of the Plan, a non-interest bearing HCSA will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the contributions you made for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeper account.

**Q-4. When does my coverage under the Health Care Spending Account end?**

You continue to participate in the HCSA until (i) you elect not to participate in accordance with Q-7 of Part I of the Cafeteria Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period (there are no Evergreen Elections for the HCSA); (iii) you no longer satisfy the eligibility requirements described in the Plan Information Appendix; (iv) you terminate employment with the employer; or (v) the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect Continuation Coverage (as described below) under the HCSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur: (i) the date your coverage ends; (ii) for your spouse, the date that you and your spouse divorce or legally separate (or receive an annulment); (iii) the date an individual ceases to meet the requirements of an Eligible Dependent; or (iv) the date the Plan is terminated or amended to exclude the individual or the class of dependents of which the individual is a member from coverage under the HCSA. Your covered dependents may also be entitled to continue coverage if coverage is lost for certain reasons. See Q-15 of this Appendix I to the Cafeteria Plan SPD for more information on COBRA.

For the HCSA, you will have until the end of the claim run out period for employees separated from service set forth in the Plan Information Appendix [Claim Run Out Period for Separation of Service Employees] to submit claims for expenses incurred prior to your termination date.

**Q-5. What happens to my Health Care Spending Account if I take an approved leave of absence?**

Generally, the rules described in Q-12 of Part I of your Cafeteria Plan SPD apply. However, if your HCSA coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the HCSA at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your HCSA coverage was not in effect are not eligible for reimbursement under this HCSA.

**Q-6. What is the maximum annual Health Care Spending Account amount that I may elect under the Health Care Spending Account?**

You may choose any annual HCSA amount you desire subject to the maximum and minimum annual HCSA amount set forth in the Plan Information Appendix “[HCSA Maximum,” “HCSA Minimum”]. You will be required to pay the annual contribution equal to the HCSA amount you have chosen, reduced by any Non-elective Employer Contributions (if any) allocated to your HCSA.

Any change in your election affecting annual contributions to the HCSA pursuant to Q-7 of Part I of Cafeteria Plan SPD also will change the maximum available reimbursements for the period of coverage remaining in the Plan Year. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated third party administrator) will notify you of the applicable method when you make your election change.

**Q-7. How do I pay for Health Care Spending Account benefits?**

When you complete the Salary Reduction Agreement or Election Form, you specify the HCSA amount you wish to pay for with Pretax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any Non-elective Employer Contributions (if any), allocated to your HCSA, will be deducted from each paycheck by your Employer.

For example, suppose you have elected an annual election of \$1,000 per year for Eligible Medical Expenses, and you have chosen no other benefits under the Cafeteria Plan. Your HCSA would be credited with a total of \$1,000 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of \$38.46 credited to your “HCSA” each payday.

**Q-8. What amounts will be available for Health Care Spending Account at any particular time during the Plan Year?**

Provided that you continue to pay the periodic contributions due for this benefit, the full, annual amount you have elected will be available at any time during the Plan Year, reduced by the amount of previous HCSA reimbursements received during the Year.

**Q-9. How do I receive reimbursement under the Health Care Spending Account?**

If you elect to participate in the HCSA, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an Eligible Medical Expense, you will need to submit a claim to the Plan’s third party administrator identified in the Plan Information Appendix on a claim form that will be supplied to you. Along with the claim form, you must include written statement(s)/bill(s) from an independent third party stating that the medical expense(s) have been incurred, and the amount of such expense(s). In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay.

You will generally be reimbursed for your Eligible Medical Expenses during the next processing period after which you submitted the claim. Remember, though, you can’t be reimbursed for any total expenses above the annual reimbursement amount you have elected.

To have your claims processed as soon as possible, please read the claims instructions that will be furnished to you. Please note that it is not necessary that you have actually paid for the Eligible Medical Expense -- only that you have incurred the expense (i.e., the services giving rise to the expense have been provided), and that it is not being paid for or reimbursed from any other source.

In addition, you will have until the end of the claim run out period set forth in the Plan Information Appendix “Claim Run Out Period”, to submit all claims for reimbursement of Eligible Medical Expenses incurred during the Plan Year. You will be notified in writing if any claim for benefits has been denied.

**Q-10. What is an “Eligible Medical Expense”?**

An “Eligible Medical Expense” means an expense that has been incurred by your and/or your eligible dependents that satisfies the following conditions:

- The expense is for “medical care” as defined by Code Section 213(d);
- The expense has not been reimbursed by any other sources and you will not seek reimbursement for the expense from any other source.

The Code generally defines “medical care” as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs. Not every health related expense you or your eligible dependents incur will constitute an expense for medical care. For example, an expense is not for medical care, as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition). Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute medical care as defined by the Code are not reimbursable under any Health Care Spending Account (per IRS regulations):

- Health insurance premiums; and
- Expenses incurred for qualified long term care services.

The claims and plan administrator have the authority to request additional substantiation if the claims or plan administrator deems it necessary to properly substantiate that the expense was for “medical care”.

**Q-11. When must expenses be incurred for which I may be reimbursed?**

Eligible Medical Expenses must be incurred *during* the Plan Year and while a participant. You may not be reimbursed for any expenses arising before the HCSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

**Q-12. What if the “Eligible Medical Expenses” I incur during the Plan Year are less than the annual amount I have elected for the Health Care Spending Account?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual amount you elected. Any amount allocated to a HCSA shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year within the Claim Run Out period described in the Plan Information Appendix. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

**Q-13. What happens if a Claim for Benefits under the Health Care Spending Account is denied?**

If you are denied a benefit under the HCSA, you will generally proceed in accordance with the following claims review procedures.

**Step 1:** *Notice of Denial is received from third party administrator.* If your claim is denied, you will receive written notice from the third party administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the third party administrator, the third party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2:** *Review your notice carefully.* Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

- a. the reason(s) for the denial and the Plan provisions on which the denial is based;
- b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- c. a description of the Plan’s appeal procedures and the time limits applicable to such procedures; and
- d. a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the third party administrator, you may file a written appeal. You will need to file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you may file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you may file your appeal with the third party administrator. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you will need to submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

**Step 4:** *Second Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the Plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the third party administrator.

Otherwise, the second notice of denial will be sent no later than 60 days after the Plan Administrator has received the appeal.

**Step 5:** *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

**Step 6 (if there is a second level of appeal as indicated in the notice of denial):** *If you still disagree with the third party administrator's decision, file a 2<sup>nd</sup> Level Appeal with the Plan Administrator.* If you still do not agree with the third party administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the third party administrator. You will need to gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your 2<sup>nd</sup> Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

## **Important Information**

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;

You cannot file suit in federal court until you have exhausted these appeals procedures.

### **Q-14. What happens to unclaimed Health Care Spending Account Benefits?**

Any HCSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

### **Q-15. What is COBRA continuation coverage?**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the HCSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

#### *When Coverage May Be Continued*

If you are a participant in the Health Care Spending Account, then you have a right to choose continuation coverage under the Health Spending Account if you lose your coverage because of:

- a reduction in your hours of employment; or
- a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- the death of your spouse;
- a voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- the divorce or legal separation from your spouse.

In the case of a Dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- the death of the employee;
- a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- his or her parents' divorce or legal separation; or
- he or she ceases to be a dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries".

**Q-16. Will my health information be kept confidential?**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the HCSA and the third party administrators are required to take steps to ensure that certain "protected health information is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

**PART II: Other Important Information about the Health Care Spending Account**

Participation in the Plan does not give any participant the right to be retained in the employ of his or her Employer or any other right not specified in the HCSA.

The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.

## **ERISA Rights**

The Health Care Spending Account Plan may be an ERISA welfare benefit plan. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be 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 work-sites and union halls, all documents governing the plan, including insurance contracts, 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 all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

### *Continue Group Health Plan Coverage*

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-15 of this Appendix for more information concerning your COBRA continuation coverage rights.

*(To the extent the HCSA is subject to HIPAA's portability rules)* You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another 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 the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

### Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the 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 Administrator. If you have a claim for benefits that 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.

### Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

**HAWAII RESIDENCY PROGRAM  
Flexible Benefits Plan  
SUMMARY PLAN DESCRIPTION**

**APPENDIX II – Dependent Care Spending Account SPD**

**General Information about the Dependent Care Spending Account**

You will have the opportunity to elect to receive income tax-free reimbursement (“Dependent Care Reimbursements”) for some or all of your work-related Dependent Care expenses (“Eligible Employment Related Expenses”) under the Dependent Care Spending Account (“DCSA”). Under these provisions, you provide a source of pretax contributions to reimburse yourself for your Eligible Employment Related Expenses.

**Part I: Questions & Answers**

**Q-1. Who can participate in the Dependent Care Spending Account?**

Each Employee of the Employer (or an Affiliated employer listed in the Plan Information Appendix) who satisfies the DCSA eligibility requirements as set forth in the Plan Information Appendix “DCSA Eligibility” is eligible to participate in the DCSA as of the eligibility date set forth in the Plan Information Appendix “[DCSA Eligibility Date]”.

**Q-2. How do I become a Participant?**

You become a Participant in the DCSA by electing a specific level of Dependent Care Reimbursement benefits during the Initial or Annual Election Periods. (The Initial and Annual Election Periods are described above in Q-6 of Part I of the Cafeteria Plan SPD.) Your participation in the DCSA will be effective on the date that you make an election or your DCSA Eligibility date.

**Q-3. What is my “Dependent Care Spending Account”?**

If you elect benefits under this portion of the Plan, a non-interest bearing DCSA will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the contributions you made for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

**Q-4. When does my coverage under the Dependent Care Spending Account end?**

You continue to participate in the DCSA until (i) you elect not to participate in accordance with Q-7 of Part I of the Cafeteria Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period (there are no Evergreen Elections for the Dependent Care Spending Account); (iii) you no longer satisfy the eligibility requirements described in the Plan Information Appendix; (iv) you terminate employment with the employer (there are special rules for terminating employees).; or (v) the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

For DCSA, you will have until the end of the claim run out period for separated from service employees set forth in the Plan Information Appendix “Claim Run Out Period for Separation of Service Employees” to submit claims for expenses incurred prior to your termination date.

**Q-5. What happens to my Dependent Care Spending Account if I take an unpaid leave of absence?**

Generally, the rules described in Q-12 of your Cafeteria Plan SPD apply to the DCSA.

**Q-6. What is the maximum annual Dependent Care Spending Account amount that I may elect under the Dependent Care Spending Account?**

You may choose any annual DCSA amount you desire subject to the maximum amount specified in Section 129 of the Internal Revenue Code or set forth in the Plan Information Appendix (cannot exceed IRS Code Section 129 maximum) “DCSA Maximum”. The IRS Code Section 129 maximum amount is currently \$5,000 per Plan Year if you:

- a) are married and file a joint return;
- b) are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DCSA, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- c) are single, or a head of household for tax purposes.

If you are married, reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is \$2,500. In addition, the amount of reimbursement that you receive cannot exceed the lesser of the earned income (as defined in Code Section 32) of you or your spouse. For purposes of (b) above, your spouse will be deemed to have Earned Income of \$250 (\$500 if you have two or more Qualifying Individuals described in paragraph 2 of Q-8), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself; or (ii) a full-time student (as defined by Code Section 21).

**Q-7. How do I pay for Dependent Care Spending Account benefits?**

When you complete the Salary Reduction Agreement or Election Form, you specify the DCSA amount you wish to pay for with Pretax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any Non-elective Employer Contributions (if any) allocated to your Dependent Care Spending Account, will be deducted from each paycheck by your Employer.

For example, suppose you have elected an annual election of \$2,600 per year for Eligible Employment Related Expenses, and you have chosen no other benefit under the Cafeteria Plan. Your DCSA would be credited with a total of \$2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of \$100 credited to your “DCSA” each payday to pay reimbursements under this Plan. The amount that is available to your DCSA at any particular time will be whatever has been credited to such DCSA less any reimbursements already paid.

**Q-8. What is an “Eligible Employment Related Expense” for which I can claim a reimbursement?**

You may be reimbursed for work-related dependent care expenses (“Eligible Employment Related Expenses”). Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive DCSA benefits and during the calendar year to which it applies.
2. Each individual for whom you incur the expenses is a “Qualifying Individual”. A Qualifying Individual is:
  - (a) a Dependent age 12 or under who resides with you and for whom you are entitled to a personal tax exemption as a dependent (as defined by Code Section 151 (c)); however, if you are divorced, the child is a qualifying individual with respect to you if the child lives with you even if you have permitted the non-custodial parent to take the exemption, or
  - (b) a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.
4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
6. The expense is not paid or payable to a child of yours who is under age 19 at the end of the year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 “Your Federal Income Tax” for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

**Q-9 How do I receive reimbursement under the Dependent Care Spending Account?**

If you have elected to participate in the DCSA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you will need to submit a claim to the Plan’s third party administrator identified in the Plan Information

Appendix on a claim form that will be supplied to you. If your account balance is sufficient, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current DCSA balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your DCSA. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions that will be furnished to you. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense (i.e., the services giving rise to the expense have been provided), and that it is not being paid for or reimbursed from any other source.

In addition, you will have until the end of the claim run out period set forth in the Plan Information Appendix [Claim Run Out Period], to submit all claims for reimbursement for Eligible Employment Related Expenses incurred during the Plan Year. You will be notified in writing if any claim for benefits has been denied.

**Q-10. What if the "Eligible Employment Related Expenses" I incur during the Plan Year are less than the annual amount of coverage I have elected for the Dependent Care Spending Account?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred and the annual amount you have elected. Any amount allocated to a DCSA shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year within the Claim Run Out period described in the Plan Information Appendix. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs and/or otherwise permitted under applicable law.

**Q-11. Will I be taxed on the Dependent Care Spending Account benefits I receive?**

You will not normally be taxed on your Dependent Care reimbursements, provided that your family's aggregate DCSA reimbursement (under this DCSA and/or another employer's DCSA) does not exceed the limits set out in Q-6 of this Appendix II of the Cafeteria Plan SPD. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

**Q-12. If I participate in the Dependent Care Spending Account, will I still be able to claim the household and dependent care credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this DCSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

**Q-13. What is the household and dependent care credit?**

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of \$1,050 for one Qualifying Individual or \$2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross incomes over \$15,000.

**Illustration:** Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of \$3,600, and that your adjusted gross income is \$21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each \$2,000 of your adjusted gross income over \$15,000. The calculation is:  $35\% - [(\$21,000 - 15,000)/\$2,000 \times 1\%] = 32\%$ . Thus, your tax credit would be  $\$3,000 \times 32\% = \$960$ . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been  $\$3,600 \times 32\% = \$1,152$ , because the entire expense would have been taken into account, not just the first \$3,000.

**Q-14. What happens to unclaimed Dependent Care Spending Account Benefits?**

Any DCSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

**Q-15. What happens if my claim for reimbursement under the Dependent Care Spending Account is denied?**

If you are denied a benefit under the DCSA, you will generally proceed in accordance with the following claims review procedures.

**Step 1:** *Notice of Denial is received from third party administrator.* If your claim is denied, you will receive written notice from the third party administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the third party administrator, the third party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2:** *Review your notice carefully.* Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

- a. the reason(s) for the denial and the Plan provisions on which the denial is based;

- b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- d. a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the third party administrator, you may file a written appeal. You will need to file your appeal no later than 180 days of receipt of the notice described in Step 1.

**PART II: Other Important Information about the Dependent Care Spending Account.**

Participation in the Plan does not give any participant the right to be retained in the employ of his or her employer or any other right not specified in those plans.

The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.

**APPENDIX III – Plan Information Appendix  
To the HAWAII RESIDENCY PROGRAM Plan  
SUMMARY PLAN DESCRIPTION**

This Appendix provides information specific to the **HAWAII RESIDENCY PROGRAM Cafeteria Plan**.

**A. EMPLOYER/PLAN SPONSOR INFORMATION**

1.	Name, address & phone number of Client or Plan Sponsor:	<b>HAWAII RESIDENCY PROGRAM 1356 Lusitana Street, Room 510 Honolulu, HI 96813 (808) 528-1495</b>
2.	Name, address & phone number of Plan Administrator:	<b>HAWAII RESIDENCY PROGRAM 1356 Lusitana Street, Room 510 Honolulu, HI 96813 (808) 528-1495</b>
3.	Federal Tax Identification	<b>99-0215841</b>
4.	Controlling Law:	<b>Hawaii</b>
5.	Plan Number:	<b>502</b>
6.	The initial Plan Year:	<b>August 1 through July 31</b>
7.	All subsequent Plan Year (if different from 6):	<b>--</b>
8.	Third Party Administrator:	<b>Creative Benefits, Inc. P.O. Box 1928 Vista, CA 92085-1928</b>
9.	COBRA Administrator:	<b>Self-administered</b>
10.	Claim Run Out Period:	<b>3 months after end of plan year</b>
11.	Claim Run Out Period for Separation of Service employees	<b>3 months after termination date</b>
12.	Adopting Employers participating in the Plan:	<b>1. N/A</b>

**B. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, AND ELECTIONS**

- (a) **Cafeteria Plan.** Each Employee who is a **regular full-time employee** and who is eligible for coverage or participation under any of the Benefit Package Options will be eligible to participate in this Plan on the **date of hire** (“Eligibility Date”).

The Employee’s commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in the SPD. Eligibility for coverage under any given Benefit Package Option shall be determined not by this Plan but by the terms of that Benefit Package Option.

- (b) **Health Care Spending Account.** Each employee who is a **regular full-time employee** shall be eligible to participate in the HCSA on the **first of the month following a 6-month waiting period** (“HCSA Eligibility Date”).
- (c) **Dependent Care Spending Account.** Each Employee who is a **regular full-time employee** shall be eligible to participate in the DCSA on **date of hire** (“DCSA Eligibility Date”).
- (d) **Annual Elections.** With respect to Benefit Package Option elections (other than the HCSA and DCSA elections, when offered under the Plan), failure to make an election during the Annual Election Period will result in the follow deemed election(s):

- The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Package Options offered under the Plan will end the last day of the Plan Year in which the Annual Election Period occurred.
- The employee will be deemed to have elected to continue his Benefit Package Option elections in effect as of the end of the plan Year in which the Annual Election Period took place, unless employee notifies the company in writing of a qualifying status change or at any time before the end of the Plan Year for the following Plan Year. This is called an “Evergreen election”.

- (e) **Change of Election Period.** If you are able to change your election during the year in accordance with Q-7 of Part I of this SPD, you must submit a change of election form within **30 days**.

**C. BENEFIT PACKAGE OPTION(S) PROVIDED UNDER THE PLAN**

The Employer elects to offer to eligible Employees the following Benefit Package Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Package Options. These component Benefit Package Options are specifically incorporated herein by reference. The maximum Pretax Contribution amount a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Package Options selected minus any Non-elective Contribution made by the Employer. It is intended that such Pretax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

(a) **Benefit Package Options.** The following Benefit Package Options are made available under the Plan to all those eligible Employees who make an appropriate election.

- 1) **Medical**
- 2) **Dental**
- 3) **Vision**
- 4) **Cancer/Catastrophic Illness**

(b) **Cash-Out Option.** Additional taxable compensation for certain Employees who opt-out of certain Benefit Package Options or who do not use all of the allotted amount of Non-elective Contributions (as described in the enrollment materials) is offered under the Plan. The available Cash-Out Option amount will be set forth in the enrollment material.

(c) **Health Care Spending Account.** Health Care Reimbursement under the HCSA shall not exceed the lesser of the amount elected under the Plan or **\$1,200**, per Plan Year, pursuant to the terms of the HCSA described in the HCSA Appendix of the SPD.

This amount is prorated for the number of months in which the HCSA is effective (if less than twelve months) or the number of months that the Participant's Salary Reduction Agreement is effective within such Plan Year, whichever is less.

(d) **Dependent Care Spending Account.** Dependent Care Reimbursement under the DCSA shall not exceed the lesser of the amount elected under the Plan or **\$5,000** per Plan Year (or \$2,500 for married filing separate returns), pursuant to the terms of the DCSA described in the DCSA Appendix of the SPD.

This amount is prorated for the number of months in which the DCSA is effective (if less than twelve months) or the number of months that the Participant's Salary Reduction Agreement is effective within such Plan Year, whichever is less.

