THE WILKES UNIVERSITY CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

<u>Introduction</u>

Wilkes University (the "Employer") sponsors the Wilkes University Cafeteria Plan (the "Cafeteria Plan") that allows eligible Employees to **choose from a menu of different benefits paid for with pre-tax dollars.** (Such plans are also commonly known as "salary reduction plans" or "Section 125 plans").

This Summary Plan Description ("Summary") describes the basic features of the Cafeteria Plan, how it generally operates and how Employees can gain the maximum advantage from it.

PLEASE NOTE: This Summary is for general informational purposes only. It does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan documents and this Summary, then the Cafeteria Plan documents will control.

Cafeteria Plan

CAFQ-1. How do I pay for Wilkes University Cafeteria Plan benefits on a pre-tax basis?

You may elect to pay for benefits on a pre-

CAFQ-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following benefit plans:

The Health Flexible Spending Arrangement permits an Employee to use "pretax" dollars to pay for his or her qualifying Medical Care Expenses (defined in HFSA Q-7) that are not otherwise reimbursed by insurance.

The permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined in DCAP Q-7) with pre-tax dollars.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you as necessary from time to time.

CAFQ-3. Who can participate in the Cafeteria Plan?

Employees who are working 35 or more hours per week are eligible to participate in the Cafeteria Plan following 0 calendar days of employment with the Employer, provided that the election procedures in CAF Q-5 are followed.

An "Employee" is any individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include the following: any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRSor others to be a common-law employee of the Employer, any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRSor others to be a common-law employee of the Employer, any self-employed individual, any partner in a partnership, any more-than-2% shareholder in a Subchapter Scorporation and any employee covered under a collective bargaining agreement.

CAF Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security/Medicare) taxes by participating in the Wilkes University Cafeteria Plan.

Example CAFQ4(a): Suppose Sally pays 15% in federal income taxes for the year. With an annual salary of \$30,000, that could mean as much as \$4,500 in federal income taxes, plus

\$2,295 in FICA taxes (calculated at 7.65% of income). But by electing \$2,000 of cafeteria plan benefits for the year, Sally lowers her taxable income by \$2,000, meaning she is only taxed on \$28,000. This comes out to \$4,200 in income tax plus \$2,142 in FICA tax. That's a \$453 tax savings for the year.

(Caution: This example is intended to illustrate the general effect of "pre-taxing" benefits through a cafeteria plan. It does not take into account the effects of filing status, tax exemptions, tax deductions and other factors affecting tax liability. Furthermore, the amount of the contributions used in this example is not meant to reflect your actual contributions. It is also not intended to reflect specifically upon your particular tax situation. You are encouraged to consult with your accountant or other professional tax advisor with regard to your particular tax situation.)

CAFQ-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements, you may enter the plan the first day of the month coinciding with or following the date the eligibility requirements have been met. You can become a Participant by electing benefits in a manner such as described in CAFQ-1. An eligible Employee who does not elect benefits will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in CAFQ-7).

An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-8 and CAF Q-12 for more information about this as information about how termination of participation affects your Benefits.

CAFQ-

The "Open Enrollment Period" is the period during which you have an opportunity to participate under the Cafeteria Plan by electing to do s

Year (this is known as the "irrevocability rule"). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

However, there are several important exceptions to the irrevocability rule, many of which have to do with events in your personal or professional life that may occur during the Plan Year. Be advised, however, that there are very few exceptions applicable to Health FSAs.

Here are the exceptions to the irrevocability rule:

1. Leaves of Absence

(Applies to Health FSA and DCAP Benefits.)

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in CAF Q-14.

2. Change in Status.

(Applies to Health FSA Benefits as Limited Below and to DCAP Benefits.)

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 in item 3 below). Those occurrences that qualify as ances

- Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) 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 Cafeteria 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.
- DCAP Benefits. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP, or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care 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 DCAP as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care coverage 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 DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does.

For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

- DCAP Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.
- 9. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined in CAFQ-14); Changes in Status; Special Enrollment Rights;

Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, as explained hereafter in this CAF Q-7, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. If the

change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance
Benefits, then the change will be deemed effective as of the date that eligibility is lost due to
the occurrence of the Change in Bection Event, even if you do not request it within 30 days.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or

CAF Q-9. Will I pay any administrative costs under the Cafeteria Plan?

No. Administrative costs shall be borne by the Employer, which reserves the right to offset these costs with available Cafeteria Plan forfeitures.

CAF Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of t to

COBRA.

For a discussion of your Continuation and Reinstatement rights please refer to Appendix A.

USERRA.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

CAF Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable income, which may result in a decrease in your Social Security benefits and/or other benefits which are based on taxable income. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits. If you are still unsure, you are encouraged to consult with your accountant or other tax advisor.

CAFQ-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence.

NOTE: The following shall only apply if the Employer is subject to the federal Family and Medical Leave Act of 1993 (FMLA).

If you go on a qualifying leave under the federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay it

compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is h

Health FSA Benefits

HFSA Q-

As described in Q-

counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar

month.

(November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges \$5,000. Rachel is required to pay a \$2000 down payment and \$200 for each month thereafter. She decides to pay the entire \$5000 during the first visit to avoid any interest being charged. The entire \$5000 will be reimbursable from her 2008 health FSA.

PLEASE NOTE: "Down" payments for orthodontia are immediately reimbursable.

HFSA Q-8. When must the Medical Care Expenses be incurred for the Health FSA?

For expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they

In cases where you do not use an electronic payment card or "debit" card to pay for your incurred expenses, you must submit a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

You will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension in certain instances—see CAF Q-11 for more information). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have 3 months after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 3 months after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible (or during any applicable grace period). You will be notified in writing if any claim for benefits is denied. (See CAF Q-11 for more information.)

The following additional rules will apply to Medical Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

- Medical Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that \$300 remains in your Health FSA Account at the end of the 2009 Plan Year and that you have also elected \$3000 of Health FSA coverage for 2010. If you submit a \$700 Medical Care Expense that was incurred on January 15, 2010, \$300 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2009 Plan Year and the remaining \$400 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2010 Plan Year.
- Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$700 grace period expense; you discover \$400 of 2009 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by 3 months after the close of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date—see HFSA Q-9).

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all

DCAP Benefits

DCAP Q-

As described in CAFQ-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP).

As described in CAFQ-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes.

See CAFQ-4 for an example dealing with pre-tax payment of Medical Insurance contributions.

DCAP Q-2. Can I participate in the DCAP Benefit?

Eligibility requirements for the DCAP Benefit are different than the eligibility requirements described under CAF Q-3. Employees who regularly work 35 or more hours per week, regularly work 6 or more months per Plan Year, have been employed by the Employer for 0 consecutive calendar days, counting his or her Employment Commencement Date as the first such day, and are employed by a participating Employer may participate in the DCAP Benefit.

After you satisfy the eligibility requirements described above, you may participate in the DCAP on the first day of the month coinciding with or following the date the eligibility requirements have been met by signing an individual Election Form/Salary Reduction Agreement as described under CAF Q-5.

DCAP Q-

If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer) and it does not bear interest.

DCAP Q-4. What are the maximum DCAP Benefits that I may elect under the Cafeteria Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of \$0.00 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect \$3,000 in DCAP Benefits, you'll pay for the benefits with a \$3,000 salary reduction).

The amount of coverage that is available for reimbursement of qualifying Dependent Care

- the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status, as described further in Q-4.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is \$5,000.

DCAP Q-8. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP

with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension in certain instances—see CAF Q-11). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the 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 DCAP Account.

You will have 3 months after the end of the Plan Year in which to submit a daim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 3 months after the date you ceased to be eligible in which to submit a daim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible. You will be notified in writing if any daim for benefits is denied. (See CAF Q-11.)

The following additional rules will apply to Dependent Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

- Dependent Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that \$200 remains in your DCAP Account at the end of the current Plan Year and that you have also elected \$2,400 of DCAP coverage for the new Plan Year. If you submit a \$500 Dependent Care Expense that was incurred on January 15, of the new Plan Year, \$200 of your daim will be paid out of the unused amounts remaining in your DCAP Account from the current Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the new Plan Year.
- Once paid, a daim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$500 grace period expense, you discover \$200 of 2009 Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2010 expenses. The Plan will not reprocess the \$500 grace period expense so as to pay it entirely from your 2010 Dependent Care amounts. For this reason, if you also have Dependent Care coverage for the current year, you may want to wait to submit Dependent Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- Expenses incurred during a grace period must be submitted by the 90 day(s) following the close of the Plan Year to which the grace period relates in order to be reimbursed

from amounts remaining at the end of that Plan Year. (As discussed above, 90 days is also the deadline for submitting any claims for reimbursement of Dependent Care Expenses incurred during the preceding Plan Year.)

To have your daims processed as soon as possible, please read CAFQ-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in DCAPQ-8) and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Dependent Care Account, some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, Dependent Care Expenses incurred during a Grace Period may need to be submitted manually in order to be reimbursed from unused amounts in your Dependent Care Account from the preceding Plan Year if the card is unavailable for such reimbursement.

DCAP Q-10. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period—see DCAP Q-8) are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount—this is called the "use-or-lose" rule under applicable tax laws and it is one of the required trade-offs for the tax benefits gained. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year or its grace period (if applicable), even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the end of the time limits described in DCAP Q-11.

DCAP Q-11. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year within 3 months after the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 3 months after the date you ceased to be eligible—see DCAP Q-9). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased b

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in DCAP Q-4. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal

For more information about how the Dependent Care Tax Oredit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor, as discussed below.

DCAP Q-15. Would it be better to include the DCAP Benefits in my income and daim the Dependent Care Tax Oredit, instead of treating the reimbursements as tax free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you.

Miscellaneous

MISCQ-1. What are my ERISA Rights?

The Cafeteria Plan is not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component is governed by ERISA.

Your Rights. As a participant in the Cafeteria Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 Administrator, copies of documents governing the operation of the Plan, including insurance contracts a5(U.)4(S.)7(D2(I)10(t)-1(.)-3(go-4(e0 1 73 Tm0 1 73 Tmt)-4

(PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people

This MISC Q-2 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

Official Name of the Plan: Wilkes University Cafeteria Plan

Plan Number: 501

Effective Date: June 1, 2012

Plan Year: June 1 to May 31. Your Plan's records are maintained on this period of time.

Type of Plan: Welfare plan providing Health FSA Benefits and DCAP Benefits

Employer/Plan Sponsor Information

Name and Address: Wilkes University 84 W. South St. Wilkes Barre, PENNSYLVANIA 18766

Federal employee tax identification number (\Box N): 24-0795506.

Plan Administrator Information

Name, address, and business telephone number: Wilkes University 84 W. South St. Wilkes Barre, PENNSYLVANIA 18766 Attention: Human Resources Manager Telephone Number: (570) 408-4644

Funding Medium and Type of Plan Administration.

The Health FSA Component is a group health plan. The Health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes daims for the Plan, but the Employer pays all daims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of daims) of the Plan.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Wilkes University 84 W. South St. Wilkes Barre, PENNSYLVANIA 18766 Telephone Number: (570) 408-4644

Agent for Service of Legal Process

Appendix A

premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA coverage lasts only until the end of the plan year

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable daims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.

All qualified beneficiaries are covered together under the Health FSA unless otherwise elected

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Wilkes University for more information.

No Health FSA open enrollment

Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of uollowing (

pt tq

reso

- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal

Contact Wilkes University for more information about the special second election period.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify Wilkes University of any of these qualifying events.

Caution:

You stop being eligible for coverage as dependent child whenever you fail to satisfy any part of the plan's definition of dependent child.

You must notify the plan administrator of certain qualifying events by this deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent

be available to you only if you notify Wilkes University in writing within 60 days after the

If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period O ELECT COBRA

COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

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

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum

maximum of 29 months. This extension is availabl

dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify Wilkes University of a second qualifying event by this deadline

This extension due to a second qualifying event is available only if you notify Wilkes University in writing of the second qualifying event within 60 days after the date of the second qualifying event.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

of Second Qualifying (you may obtain a copy of this form from Wilkes University at no charge, and you

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify Wilkes University if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify Wilkes University in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from Wilkes University at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify Wilkes University of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify Wilkes University if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Wilkes University of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled

(you may obtain a

copy of this form from Wilkes University at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any daim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility reothn

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from Wilkes University without charge. Oral notice, including notice by telephone, is not acceptable. Bectronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to:

Human Resources Director
Wilkes University
84 W. South St.
Wilkes-Barre, PENNSYLVANIA 18766

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from Wilkes University).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline," "You must notify Wilkes University of a qualified beneficiary's disability by this deadline," and "You must notify Wilkes University of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (Wilkes University Welfare Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying Wilkes University that your Plan

coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to Wilkes University that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.