The University of Alabama in Huntsville

Preferred Blue Flexible Spending Plan

Effective January 1, 2011

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WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your Flexible Spending Plan. The following information summarizes your group's Preferred Blue Flexible Spending Plan. This booklet serves as one of the plan documents and as a summary plan description.

Blue Cross and Blue Shield of Alabama is an **independent** corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association.

If you have any questions which the person in your company who deals with employee benefits cannot answer, please contact the Blue Cross and Blue Shield of Alabama Customer Service Department.

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact Customer Service at 1-800-213-7930. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish

Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-213-7930. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

PREFERRED HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

Participation in the Health FSA

Participating Companies

The Health FSA is available to participating companies and designated divisions of other companies (referred to as "the company") that have elected to participate in the Health FSA. Contact your employer's Benefits Office if you have any questions about whether your employer is a participating company.

Eligibility

All employees classified by the company as regular, full-time, employees are eligible to participate in the Health FSA.

Your Enrollment Decision

Participation in the Health FSA is voluntary. Each year, during the annual open enrollment period for the Preferred Blue Accounts, you will have an opportunity to enroll in the Health FSA or make a new deposit decision that will be effective as of the first day of the next plan year.

New hires can enroll in the Health FSA when they are hired.

You will receive enrollment information from your employer's Benefits Office.

Contributions to the Account

During the annual enrollment period, you decide how much you want to contribute to your Health FSA for the following plan year. You can direct up to a maximum of $3,900 to your account each year to pay for eligible health care expenses. There is no minimum annual contribution.

In the case of a new hire, you decide how much you want to contribute for the balance of the year following your date of hire.

Contributions are made on a pretax basis and deducted from your paycheck each pay period during the plan year. The "plan year" is January 1st through December 31st each calendar year.

The company reserves the right to limit the contributions and reimbursements to highly compensated employees for the plan to satisfy certain nondiscrimination tests under federal law.

Use It or Lose It Rule

Before deciding how much to contribute in your account, it's important to carefully consider your health care needs and estimate your expenses for the year. You need to plan carefully because under current IRS regulations, you forfeit any money left in your account after all eligible expenses have been reimbursed. This is often referred to as the "use it or lose it" rule.

Timely Filing Period

You have 90 days (normally March 31 for calendar year plans) after the end of the plan year in which to submit Requests for Reimbursement. This applies only to eligible health care expenses that were incurred during the plan year.

Submitting Requests for Reimbursement

You will have until the end of the timely filing period to submit a Request for Reimbursement. At the end of the timely filing period, if there are unused funds in your Health FSA, those funds will be forfeited and used by the Company to help cover the plan's administrative costs.

Also note that the money you direct into your Health FSA can be used only to pay for eligible health care expenses. You can't pay for dependent care expenses from the Health FSA, nor can you pay for health care expenses from the Dependent Care Account. In addition, funds assigned to one account cannot be transferred to the other under any circumstances.

Permitted Election Changes

Once you are enrolled in the Health FSA, you may increase or decrease your contributions for the remainder of a plan year if you have a change in status. A change in status occurs if:

- you marry, divorce, become legally separated, or have your marriage annulled;
- you or your spouse gives birth to or adopts a child (including placement for adoption);
- your spouse or a dependent dies;
- you or your spouse or your dependent begins or terminates employment, participates in a strike or lockout, or begins or returns from an unpaid leave of absence;
- you or your spouse or dependent has a change in employment status that causes you, your spouse, or dependent to become eligible (or cease to be eligible) to participate in this program or a program covering your spouse or dependent (for example, switching from full-time to part-time employment or from hourly to salaried status);
- your dependent qualifies or ceases to qualify as a dependent for purposes of Internal Revenue Code Sections 105(b) and 106(a);
- a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires coverage for your child or requires your spouse, former spouse or other individual to provide coverage for the child and that coverage is, in fact, provided; or,
- you or your spouse or dependent become enrolled in Medicare or Medicaid or lose eligibility for coverage under Medicare or Medicaid.

Any change in the amount of your contribution must be consistent with the change in status that has occurred. For example, if you or your spouse has a baby, you could elect to increase your contributions to your account to cover an increase in anticipated health care expenses. If you have a change in status that allows you to reduce your contributions, your new election amount may not be less than the greater of (a) the amount that has been deducted from your paycheck as of the date of change, or (b), the amount of reimbursements you have received as of the date of change.

If you terminate employment and are rehired within 30 days and within the same plan year, then you must resume your original Health FSA election for the remainder of the plan year. If you terminate employment and are rehired more than 30 days after your termination date and within the same plan year, then the company will apply one of the following options in a nondiscriminatory and consistent manner for all employees rehired during the plan year:

- require you to wait until the next annual open enrollment period to participate in the Health FSA;
- require you to resume your original Health FSA election for the remainder of the plan year; or
- permit you to make a new Health FSA election for the remainder of the plan year.

If you go on leave covered by the Family and Medical Leave Act (FMLA), you should check with your employer's Benefits Office to determine what your rights are. Generally, you may continue coverage under the Health FSA or revoke your existing election under the Health FSA. If you elect to continue your coverage, you may pre-pay contributions for the period of FMLA leave or make contributions on an after-tax basis during the period of FMLA leave, depending upon the personnel policies of the company.

Ask your employer's Benefits Office for further information about the ways in which you can continue to maintain your coverage under the Health FSA during FMLA leave. If, on the other hand, you wish to revoke your existing election (and coverage) under the Health FSA, then you may choose to be reinstated in your account upon returning from FMLA leave. You will not be entitled to receive reimbursements for expenses incurred during the period of FMLA leave. If you elect to be reinstated upon returning from the FMLA leave, you must choose to:

- resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments; or
- resume coverage at a level that is reduced and resume premium payments at the level in effect before the FMLA leave.

Similar rules may apply to non-FMLA leave of absence. You should contact your Benefits Office for further information.

Since you will forfeit any unused money in your account, you should carefully estimate your anticipated health care costs for the year before deciding the amount of your contribution.

How the Health FSA Works

The Health FSA allows you to set aside up to $3,900 a year, pretax, for health-related expenses not reimbursed by any other program or plan. You then use those pretax dollars to reimburse yourself for out-of-pocket health care expenses incurred on or after the date of your enrollment.

Eligible Expenses

Your Health FSA can be used to reimburse you for your own expenses, as well as those of your eligible dependents, as long as the expenses are:

- amounts paid for “medical care” as described in Internal Revenue Code Section 213(d);
- not reimbursable under any other health plan in which you participate; and
- incurred after the date of your enrollment and during the plan year; however, if your employment with the company terminates during the plan year, health care expenses must be incurred before your termination date (unless you elect coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 [COBRA]).

Specifically, health care expenses eligible under the plan are those not paid in full under any health care plan in which either you or your spouse participates, including annual deductible, copayments and fees over the usual and customary limits.

Eligible expenses do not include health, dental or life insurance premiums.

Following are some examples of health care expenses that are reimbursable by the Health FSA. This is a partial list extracted from IRS publications and is subject to change.

Allowable Health Care Expenses Include:

- acupuncture
- ambulance transportation expenses
- artificial limbs
- artificial teeth
- birth control pills prescribed by a doctor
- braille books and magazines
- car controls for handicapped
- chiropractors

- Christian Science practitioners
- contact lenses, as well as the equipment and materials required for using them
- crutches
- dental fees
- doctors' fees
- drug and alcohol addiction treatment
- eyeglasses
- fertility enhancement (including in vitro fertilization and surgery)
- guide dogs
- hearing aids
- hospital services
- lab fees
- lead-based paint removal
- learning disability tuition
- nursing services
- optometrists
- oxygen
- prescription drugs (legend/prescription drugs which Federal Law prohibits dispensing without a prescription)
- prescribed over-the-counter drugs (drugs which are prescribed by a physician even though Federal Law does not require a prescription)
- psychoanalysis
- special schools for the handicapped
- sterilization
- surgery (other than cosmetic surgery)
- therapy (medical)
- transplants of organs
- transportation to/from health care provider
- weight-loss plans prescribed by a physician to treat a specific disease
- wheelchairs
- X-rays

For a more complete list of eligible expenses, consult your personal tax advisor or refer to IRS publication 502, Medical and Dental Expenses which contains a list of deductible expenses. (This publication can be obtained through your local IRS office or over the Internet.) **Note:** Misuse of spending account funds is a violation of Internal Revenue Service regulations.

Eligible Dependent Expenses

Your Health FSA can be used not only to cover your own expenses, but also can be used for the cost of services received by your spouse and your dependents who qualify as dependents for purposes of Internal Revenue Code Sections 105(b) and 106(a), even if they're not covered by the company's health or dental plan.

Under IRS regulations, eligible expenses incurred by your dependents, as described in Internal Revenue Code Sections 105(b) and 106(a), are eligible for reimbursement from your Health FSA. If you have a question as to whether or not a dependent is eligible, you should consult with the IRS or your personal tax advisor for more information.

What the Plan Doesn't Cover

Although the Health FSA covers a wide variety of health care expenses, there are some expenses that are not eligible for payment. For example, expenses you incur in connection with activities that are merely beneficial to your general health and not directly related to specific health care are not reimbursable. And, as already noted, eligible expenses do not include health, dental, or life insurance premiums. Other types of health care that are not eligible include:

- expenses incurred for health clubs, spas and weight loss programs (unless prescribed by a physician solely for the purpose of treating an illness or accident);
- over-the-counter medicines and drugs unless prescribed by a physician and submitted with a copy of the prescription;
- expenses for which you receive benefits from any health, dental, vision or other health care plan;
- most kinds of cosmetic health services and supplies (unless medically necessary and not covered by a health plan), hair transplants, electrolysis, and teeth whitening;
- dietary and herbal supplements such as vitamins, fiber, and minerals (unless prescribed by a physician solely for the purpose of treating an illness).

The general rule is this: Health expenses are eligible for reimbursement from the account only if they're expenses paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Tax Effects

The Health FSA can help you reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The Health FSA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the Health FSA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you may not claim a tax deduction for health care expenses that are reimbursed through the Health FSA. You may, however, take an itemized tax deduction for any expenses in excess of your Health FSA contribution, up to the allowable limits under the law. Keep this in mind when determining whether or not to participate in the program, and contact your personal tax advisor if you have any questions.

The company is required to report the amount you contributed to the program on your annual W-2 form. It is your responsibility to determine if reimbursements are excludable from your income under Internal Revenue Service rules. Again, contact your personal tax advisor, or your local IRS office, if you have any questions.

IRS Non-Discrimination Requirements

The Health FSA is required to satisfy certain non-discrimination rules under Sections 125 and 105(h) of the Internal Revenue Code. Your employer is responsible for testing the plan to see whether it complies with these rules. If necessary, your employer may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by your employer to satisfy these rules.

Request for Reimbursement

What Constitutes a Request for Reimbursement

The Health FSA is designed to reimburse you for costs not covered by your health or dental plan and for expenses you have already paid.

If you file a primary health or dental claim with Blue Cross and Blue Shield of Alabama and no secondary coverage is reflected on your contract, it will not be necessary to file for reimbursement of any non-paid amount (unless you use a Preferred Flex Card to pay the expense). These non-paid expenses will automatically be filed and processed under your Health FSA if the funds are available. For other eligible expenses, the Preferred Blue Customer Service Center must receive a properly completed and filed Request for Reimbursement from you or your authorized representative.

In order for the Preferred Blue Customer Service Center to treat a submission by you or your authorized representative as a Request for Reimbursement, it must be submitted on a properly completed Request for Reimbursement. You should call the Preferred Blue Customer Service Center and ask for the proper Request for Reimbursement form. Alternatively, you may obtain a Request for Reimbursement form from the web site www.bcbsal.com. Simply fill it out and attach Explanation of Benefits (EOB) forms, bills, invoices, receipts, or other supporting statements showing the amount of the health-related expenses for which you are claiming reimbursement. For over-the-counter drugs you must also attach a copy of the physician's prescription for the drug. Send the Request for Reimbursement form and attachments to the Preferred Blue Customer Service Center at Post Office Box 11586, Birmingham, Alabama 35202-1586. Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period set forth above. After the close of that period any money in the account is forfeited unless subject to a properly filed Request for Reimbursement or appeal.

If the Preferred Blue Customer Service Center receives a submission that does not qualify as a Request for Reimbursement, it will notify you or your authorized representative of the additional information needed. Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period. After the timely filing period, any money in the account is forfeited unless subject to a properly filed Request for Reimbursement or appeal.

Processing of Requests for Reimbursement

Even if all of the information has been received that is needed in order to treat a submission as a Request for Reimbursement, from time to time additional information might be needed in order to determine whether the Request for Reimbursement is payable. If additional information of this sort is needed, you will be asked to furnish it, and further processing of your Request for Reimbursement will be suspended until the information is received. You will have 45 days to provide the information.

Ordinarily, you will be notified of a decision within 30 days of the date on which your Request for Reimbursement is filed. If it is necessary to ask for additional information, you will be notified of that decision within 15 days after the requested information is received. If the information is not received, your Request for Reimbursement will be considered denied at the expiration of the 45-day period you were given for furnishing the information.

In some cases, you may be asked for additional time to process your Request for Reimbursement. If you do not wish to give the additional time, your Request for Reimbursement will be processed based on the information already provided. This may result in a denial of your Request for Reimbursement.

Payment of Requests for Reimbursement

Your Request for Reimbursement will be reimbursed in full, up to the total amount you agreed to contribute to the Health FSA for the year less previous reimbursements, regardless of the amount that has been deducted from your paycheck when the expense is submitted. Your payroll deductions throughout the year will be used to repay your account if your account does not have sufficient funds at the time to pay the Request for Reimbursement.

The minimum reimbursement is $10. If your Request for Reimbursement is less than $10, you will not be reimbursed until your total Requests for Reimbursement reach the $10 minimum. Only at year-end may the reimbursed amount be less than $10.

Reimbursement checks are processed daily and mailed to your home address as shown on payroll records. A statement of account will be mailed with each check. You will also receive a quarterly statement showing the amount deposited in your account, the Requests for Reimbursement paid, the remaining balance and any pending Requests for Reimbursement.

Preferred Flex Card

If you elect to participate in the Health FSA, you may be issued a stored-value card which is called the Preferred Flex Card. The Preferred Flex Card works much like a credit card, but unlike a credit card, it gives you access to your Health FSA to pay eligible health-related expenses. The Preferred Flex Card is accepted by merchants and health care providers that have been approved by Blue Cross and Blue Shield of Alabama and that accept MasterCard®. When you use the card, the amount of the eligible expense is automatically deducted from your Health FSA in the same way that check transactions are handled.

The Preferred Flex Card can be used to pay health-related expenses which are reimbursable under the Health FSA. You should retain copies of any invoices, receipts or other documentation you receive in connection with a transaction made with the card since you may have to file these with the Preferred Blue Customer Service Center in order to substantiate your charge. In many cases, this may not be necessary. If you use the card, Blue Cross and Blue Shield of Alabama can usually use its records to substantiate your charge. If a charge is not properly substantiated or if it is otherwise determined to be for an expense not eligible for reimbursement under the Health FSA, you will be required to repay the amount of the charge. A failure to do so can result in suspension or termination of your right to use the card. You are responsible for all charges on the Preferred Flex Card, including any charges on a card issued to your dependent.

When you receive your Preferred Flex Card, you will receive a Cardholder Agreement. The card must be returned to the Preferred Blue Customer Service Center if you terminate employment.

Appeals

You or your authorized representative may appeal any adverse benefit determination. An adverse benefit determination occurs when reimbursement of your expense has been denied in whole or in part. You cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by your plan) unless you exhaust these administrative remedies.

You have 180 days following an adverse benefit determination within which to submit an appeal.

How to Appeal Adverse Benefit Determinations

In order to file an appeal you must send the Preferred Blue Customer Service Center a letter that contains at least the following information:

- your name;
- your contract number;
- sufficient information to reasonably identify the Request for Reimbursement being appealed; and,

- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Preferred Blue Customer Service Center
P.O. Box 11586
Birmingham, Alabama 35202-1586

Conduct of the Appeal

Your appeal will be assigned to one or more persons within Blue Cross and Blue Shield of Alabama who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires a medical judgment (such as whether services or supplies are medically necessary), a health care professional who has appropriate expertise will be consulted. If a health care professional was consulted during the initial decision, that same person or a subordinate of that person will not be consulted during consideration of your appeal.

If more information is needed, you will be asked to provide it. If the information is not received, denial of your appeal may be necessary.

Time Limits for Consideration of Your Appeal

You will be notified of the decision on your appeal within 60 days of the date on which you filed your appeal.

In some cases, additional time may be requested to process your appeal. If you do not wish to give additional time, your appeal will be decided based on the information already received. This may result in a denial of your appeal.

Voluntary Appeals

If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). Your voluntary appeal should be in writing, and you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

If You Are Dissatisfied

If you have filed an appeal and are dissatisfied with the response, you may ask the Preferred Blue Customer Service Center for further help.

Continuation of Your Health FSA

Your participation in the Health FSA usually ends if your employment with the company ends. However, certain circumstances may entitle you to continue participation in the Health FSA, at your own cost, for a period of time.

While on a Leave of Absence

Based on enrollment selections, if you take a leave, including leave in which you receive short-term disability benefits, you may continue to have contributions deducted from your benefit pay for your

participation to continue.

If you take an unpaid leave of absence, coverage continuation will be handled according to individual company policy. You will be responsible for continuing your account contributions on an after-tax basis. Please contact your Benefits Office for more information.

If your leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), you may revoke your existing election as described previously in the section on “Permitted Election Changes.”

If You Leave the Company

If you leave the company, you may exercise your right to continue participation in the Health FSA for a certain length of time. However, before-tax funding will no longer be available, and your Health FSA contributions will be made on an after-tax basis. Refer to the next section, "Continuation of Coverage under COBRA." Your Benefits Office will provide you with the appropriate information and application forms for this type of coverage.

Continuation of Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that most employers sponsoring health plans offer employees the opportunity for a temporary extension of that coverage when it ends or changes. Since your Health FSA is considered to be a health plan, COBRA entitles you or your spouse or dependent to extend participation in the Health FSA for the remainder of the plan year in which a COBRA qualifying event occurs. However, this COBRA continuation coverage is only available if, on the date of the COBRA qualifying event, your remaining potential annual benefits under the Health FSA are greater than your remaining contributions for the year (including the additional 2% described below).

COBRA Qualifying Events

The right of you or your spouse or dependent to elect the COBRA continuation coverage described above is permitted if coverage under the Health FSA for you or your spouse or dependent is lost because of:

- a reduction in your work hours;
- the termination of your employment (for reasons other than gross misconduct);
- your death;
- your divorce or legal separation; or
- your dependent child ceases to be a dependent under the terms of the Health FSA.

Notification Responsibilities

You or your spouse or dependent, as the case may be, are responsible for notifying your employer's Benefits Office, within 60 days of the occurrence of a COBRA qualifying event resulting from divorce, legal separation, or a dependent child ceasing to be a dependent under the terms of the program. If this 60-day notice is not provided, then the program is not required to provide the option of COBRA continuation coverage as a result of the qualifying event. After receiving notice of the qualifying event, or when the qualifying event is from death, reduction in work hours, or termination of employment, your employer's Benefits Office will notify you and your spouse and dependents of the right to choose COBRA coverage. Under the law, you have 60 days from the later of the following two dates to inform your employer's Benefits Office that you want COBRA coverage:

- the date coverage would be lost; or
- the date the COBRA election form is sent to you from your employer's Benefits Office.

If You Do Not Want COBRA Coverage

If you do not want the extended COBRA coverage, no action on your part is necessary, and your participation in the Health FSA will stop on your last date of employment. However, expenses incurred after that date will not be eligible for reimbursement from the Health FSA.

If You Elect COBRA Coverage

If you elect COBRA coverage, the company is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health FSA to similarly situated active employees. The company - not Blue Cross and Blue Shield of Alabama - is responsible for providing COBRA coverage to you if you elect it.

If a COBRA qualifying event causes a loss of coverage under the program, the type of COBRA coverage available to a qualified beneficiary (i.e., individual or family) will generally be the same as the type of coverage in effect on the date of the loss of coverage, subject to any additional adjustments specified by us or your employer or allowed for by law. If more than one qualified beneficiary is entitled to purchase COBRA coverage, all such qualified beneficiaries will be covered under one family Health FSA. If claims are received and processed by us with incurred dates preceding the loss of coverage under the Health FSA but following the date on which we have established the COBRA-FSA, we will not go back and recalculate the opening balance of the COBRA-FSA. Instead, we will process any such claims against the FSA of the member who did not have a qualifying event (usually the subscriber), or in some cases we may process the claims against the COBRA-FSA.

Payment of Contributions

If you or your spouse or dependent elect COBRA continuation coverage, the remaining contribution payments for the period of continuation coverage will be charged to you, your spouse, or dependent, as the case may be, in an amount equal to 102% of your payroll deduction amount. Payment for the additional 2% charge will be treated as an administrative charge and will not be credited to your account or the account of your spouse or dependent, as the case may be.

Your employer's Benefits Office will notify you of the amount and timing of your contributions. Your contributions will be after-tax. You should send your contributions directly to the Benefits Office unless the Benefits Office gives you instructions to the contrary. Failure to contribute to your account on a timely basis will result in termination of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage can be terminated if:

- the company no longer provides a health care spending account to any of its employees;
- the contribution for your continuation coverage is not paid on a timely basis; or
- you become covered under another group health plan.

RESPECTING YOUR PRIVACY

The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your group's human resources office.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your group). Following are circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or health care operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Benefits Office Employees
- Computer and Network Services

- The University of Alabama in Huntsville Office of Counsel/Risk Management
- Accounting and Budgets Billing Operations Employees
- The University of Alabama Systems Auditors
- Human Resources Generalists
- The Risk Analyst for The University of Alabama
- Human Resources Privacy Officer
- The UAH Privacy Officer
- Office of the Vice-President for Finance and Administration
- The UAH Faculty & Staff Clinic Coordinator
- Office of the Assistant Vice-President for Human Resources
- Human Resources Directors/Managers

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

PREFERRED DEPENDENT CARE ACCOUNT (DCA)

Participation in the DCA

Participating Companies

The DCA is available to participating companies and designated divisions of other companies (referred to as “the company”) that have elected to participate in the DCA. Contact your employer's Benefits Office if you have any questions about whether your employer is a participating company.

Eligibility

All employees classified by the company as regular, full-time, employees are eligible to participate in the DCA.

Your Enrollment Decision

Participation in the DCA is voluntary. Each year, during the annual open enrollment period for the Preferred Blue Accounts, you will have an opportunity to enroll in the DCA or make a new deposit decision that will be effective as of the first day of the next plan year.

New hires can enroll in the DCA when they are hired.

You will receive enrollment information from your employer's Benefits Office.

Contributions to the Account

During the annual open enrollment period, you decide how much you want to contribute to your DCA for the following plan year. You can direct up to a maximum of $5,000 to your account each year to pay for dependent day care expenses so you (and if married, your spouse) can work outside the home or attend school full-time. If you and your spouse file income taxes separately, the most either of you can put into a program like the DCA is $2,500. There is no minimum annual contribution.

Note: Unpaid volunteer work or volunteer work for a nominal salary does not qualify as work outside the home. Please refer to the Internal Revenue Service regulations for clarification.

Contributions are made on a pretax basis and deducted from your paycheck each pay period during the plan year. The “plan year” is January 1st through December 31st each calendar year.

Use it or Lose it Rule

Before deciding how much to contribute in your account, it's important to carefully consider your dependent care needs and estimate your expenses for the year. You need to plan carefully because under current IRS regulations, you forfeit any money left in your account after all eligible expenses have been reimbursed. This is often referred to as the “use it or lose it” rule.

Timely Filing Period

You have 90 days (normally three months) after the end of the plan year in which to submit Requests for Reimbursement. This applies only to expenses that were incurred during the plan year.

Also note that the money you direct into your DCA can be used only to pay for eligible dependent care expenses. You can't pay for health care expenses from the DCA, nor can you pay for dependent care expenses from the Health FSA. In addition, funds assigned to one spending account cannot be transferred to the other under any circumstances. Forfeitures will be used by the company to help cover the program's administrative costs.

Permitted Election Changes

Once you are enrolled in the DCA, you may increase or decrease your contributions for the remainder of a plan year if you have a change in status. A change in status occurs if:

- you marry, divorce, become legally separated, or have your marriage annulled;
- you or your spouse gives birth to or adopts a child (including placement for adoption);
- your spouse or a dependent dies;
- you or your spouse or dependent begins or terminates employment, participates in a strike or lockout, or begins or returns from an unpaid leave of absence;
- you or your spouse or dependent has a change in employment status that causes you, your spouse, or dependent to become eligible (or cease to be eligible) to participate in this program or a program covering your spouse or dependent (for example, switching from full-time to part-time employment or from hourly to salaried status);
- you or your spouse or dependent changes his or her place of residence;
- your dependent ceases to qualify as a dependent for dependent care assistance purposes; or
- there are significant changes in your child care arrangements (including changes in child care providers and changes in compensation for child care providers).

Any change in the amount of your contribution must meet consistency requirements imposed by the IRS, which means that:

- the election change is made on account of and corresponds with a change in status that affects eligibility for coverage under the plan; or
- the 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 exclusion.

For example, if your dependent qualifying child reaches the age of 13 and thereby ceases to be a qualified dependent for purposes of the DCA, you could elect to decrease the amount of your contribution to your account.

Since you will forfeit any unused money in your account, you should carefully estimate your anticipated dependent care costs for the year before deciding the amount of your contribution. Remember, unless you have a change in status, your contribution amount cannot be changed until the next plan year.

How the DCA Works

The DCA allows you to set aside up to $5,000 a year ($2,500 a year if you and your spouse file separate tax returns), before-tax, for dependent care expenses. You then use those before-tax dollars to reimburse yourself for eligible out-of-pocket dependent care expenses.

Reimbursement Limits

There is a limit on the amount of reimbursement you may receive each calendar year that is not subject to federal income tax. If you are single on the last day of the year, you may receive reimbursement up to the amount of your earned income (generally, your compensation not including reimbursement you receive from your account) for that year.

If you are married on the last day of the year, you may receive reimbursements up to the amount of your earned income or your spouse's earned income for that year, whichever is less (but not exceeding the amount in your account). For example, if your earned income is $25,000 for the year, but your spouse's earned income is only $1,500, you may receive reimbursements of up to $1,500 during that year. If you were to receive reimbursements of more than $1,500 for the year, you may have to pay federal and state income taxes on the amount you are reimbursed in excess of $1,500.

If you are married and use the DCA, your spouse must work, be a full-time student, or be disabled. In

cases where a spouse is a student or disabled, DCA calculations can be made as if that spouse earned an income of $250 per month if you have one eligible dependent, and $500 per month if you have two or more dependents.

Note: The company reserves the right to limit the contributions of and reimbursements payable to highly compensated employees, if necessary, for the plan to satisfy certain nondiscrimination tests under federal tax law.

Eligible Expenses

Your DCA can be used to reimburse you for your dependent expenses, as long as the expenses are:

- incurred so that you and your spouse can work or attend school full-time;
- incurred for services relating to the care of a dependent qualifying child under the age of 13 or your dependent or spouse who is physically or mentally incapable of caring for himself and who lives with you for more than one-half of the year; and
- incurred for services provided during the plan year. However, if your employment with the company terminates during the plan year, expenses must be incurred before your termination date.

Following are some examples of dependent care expenses that are reimbursable by the account. Eligible dependent care expenses include:

- expenses incurred for dependent day care that allow you (and if married, your spouse) to work or attend school full-time;
- licensed nursery school or day care center for children; to qualify under plan rules, the day care center must:
    - comply with all applicable state and local laws and regulations;
    - provide care for seven or more individuals; and
    - receive a fee for providing day care services;
- costs for dependent care services in or outside your home; and
- costs for household services which are in part attributable to the care of the dependent.

For expenses to be eligible for reimbursement, the person you pay to provide care for your eligible dependents cannot be your spouse, another dependent, or a child of yours under the age of 19.

For more information about eligible dependent care expenses, refer to IRS Publication 503, Child and Dependent Care Credit. This publication can be obtained through your local IRS office.

What the Plan Doesn't Cover

Certain dependent care expenses are not covered under the DCA. Examples of ineligible expenses include but are not limited to:

- any amounts you pay to an immediate family member under the age of 19 or any person you claim as a dependent on your federal income tax return;
- costs for any person caring for your dependents when you or your spouse are not working, except in cases of short temporary absences or part-time employment where the dependent care expenses are required to be paid on a periodic basis that includes both days worked and days not worked;
- transportation expenses not provided by your dependent care provider;
- child support payments;
- education expenses for kindergarten and above or overnight camp expenses;
- food, clothing and entertainment; and
- cleaning and cooking services not provided by the care provider.

Eligible Dependents

As defined by the IRS, an eligible dependent may be a qualifying child (as defined in Internal Revenue Code Section 152) who is under the age 13, or a dependent who is physically or mentally incapable of self-care, who lives with you for more than one-half of the year and who qualifies as a dependent for federal income tax purposes. The dependent must live in your home at least eight hours a day.

Tax Effects

By paying dependent care expenses through the DCA, you can help reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The DCA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

IRS Requirements

The Dependent Care Accounts of all employees participating in the plan are required to satisfy certain nondiscrimination rules under Sections 125 and 129 of the Internal Revenue Code. The plan administrator is responsible for testing the plan to see whether it complies with these rules. If necessary, the plan administrator may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by the plan administrator to satisfy these rules.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the DCA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you may not claim a tax deduction for child care expenses that are reimbursed through the DCA. You may, however, take a tax credit for any expenses in excess of your family care account contribution, up to the allowable limits under the law. Keep this in mind when determining whether or not to participate in the DCA, and contact your personal tax advisor if you have questions.

The company is required to report the amount you contributed to the DCA on your annual W-2 form. It is your responsibility to determine if the amounts reimbursed to you for dependent care expenses are excludable from your income under Internal Revenue Service rules. Again, contact your personal tax advisor, or your local IRS office, if you have any questions.

How to File a Request for Reimbursement

The DCA is designed to reimburse you for eligible dependent care expenses you already have paid. To receive DCA reimbursements, follow the steps outlined in this section.

When you have an eligible day care expense, you pay it. Then, to receive reimbursement from your account, you must submit a completed Dependent Care Account Request for Reimbursement. Bills, invoices, receipts, cancelled checks, or other supporting statements from your dependent care provider must accompany the Request for Reimbursement. Mail the Request for Reimbursement and supporting statements to:

Blue Cross and Blue Shield of Alabama
Post Office Box 11586
Birmingham, Alabama 35202-1586

Your Dependent Care Account Request for Reimbursement will be reimbursed in full, up to the balance available in your DCA at the time you submit the Request for Reimbursement. If your account doesn't have enough money to pay the expense for which you are seeking reimbursement, the Request for Reimbursement will be held until funds are available in your account.

The minimum reimbursement is $10. If your Request for Reimbursement is less than $10, you will not be reimbursed until your total Requests for Reimbursement reach the $10 minimum. Only at year-end may the reimbursed amount be less than $10.

Reimbursement checks are processed daily and mailed to your home address as shown on payroll records. A Statement of Accounts will be mailed with each check. You will also receive a quarterly statement showing the amount deposited in the account, the Requests for Reimbursement paid, the remaining balance, and any pending Requests for Reimbursement.

Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period set forth above. After the close of that period, any unused funds in the account are forfeited.

When Participation Ends

If you terminate employment and are rehired within 30 days and within the same plan year, then you must resume your original DCA election for the remainder of the plan year. If you terminate employment and are rehired more than 30 days after your termination date and within the same plan year, then the company will apply one of the following options in a nondiscriminatory and consistent manner for all employees rehired during the plan year:

- require you to wait until the next annual open enrollment period to participate in the DCA;
- require you to resume your original DCA election for the remainder of the plan year; or
- permit you to make a new DCA election for the remainder of the plan year.

Your participation in the DCA will end when you terminate employment, go on a leave of absence, retire or die. Coverage will also end if you no longer meet the eligibility rules of the plan.

You can continue to submit Requests for Reimbursement against your account through the end of the plan year in which you become ineligible. You will be reimbursed for expenses up to your remaining account balance. Any money remaining in your account at plan year-end will be forfeited.

450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service:

1-800-213-7930 toll-free

Web site:

www.bcbsal.com

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