The Southern Research Institute Flexible Spending Account Plan is administered by Blue Cross and Blue Shield of Alabama, who prepared this summary. The Flexible Spending Account Plan is made up of the Health Care FSA and the Dependent Care FSA, each outlined here separately. Another provision of the Flexible Spending Account Plan is the Premium Expense Account, which allows you to use tax-free dollars to pay your share of the cost of Southern Research’s medical, dental, and/or vision insurance plans.

**HEALTH CARE FSA**

**Eligibility**

All employees classified as full-time, post doctoral, or regular part-time are eligible to participate in the Health Care FSA.

**Your Enrollment Decision**

Participation in the Health Care FSA is voluntary. Each year, during the annual open enrollment period you will have an opportunity to enroll in the Health Care 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 Care FSA during the first 30 days after their date of hire. You will receive enrollment information from your Employee Benefits Office.

**Contributions to the Account**

During the annual enrollment period, you decide how much you want to contribute to your Health Care FSA for the following plan year. You can direct up to a maximum of $2,500 to your account each year to pay for eligible health care expenses. There is a minimum annual contribution of $360. **NOTE:** The maximum deferral will increase to $2,550 effective January 1, 2015.

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 twice monthly 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 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.

**Grace Period**

Expenses incurred during the "grace period" may be reimbursed from contributions made during the preceding plan year. This gives you a chance to "spend down" any remaining funds in your Health Care FSA if you have not already done so by the end of the plan year.
The "grace period" begins on January 1 and ends on March 15 after the end of the plan year.

Timely Filing Period

You have 30 days after the end of the grace period in which to submit Requests for Reimbursement (that is, 105 days after the close of the prior plan year). This applies to expenses incurred during the plan year and expenses incurred during the grace period. For example, if you incur an expense on the last day of the grace period (March 15, 2011), and you want this expense reimbursed from 2010 contributions, you must submit a claim for reimbursement by April 15, 2011, in order for the claim to be paid from 2010 contributions. If this claim is submitted after April 15, 2011 (in this example), reimbursement can only be made from 2011 contributions.

Order in Which Requests for Reimbursements are Processed During the Grace Period

Requests for Reimbursement received during the grace period are processed against your Health Care FSA in the order received. For example, suppose you finished the 2010 plan year with $200 in your Health Care FSA. Suppose also that you incur claims in January of 2011 of $200, and those claims are received by the Health Care FSA shortly thereafter and processed against your remaining 2010 plan year Health Care FSA balance. Your 2010 plan year balance in thus reduced to zero. If in February, for example, you submit a Request for Reimbursement of $100 incurred in December 2010, your claim will be denied since you have no remaining balance of funds in your Health Care FSA for the 2010 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 Care 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 Care FSA can be used only to pay for eligible health care expenses. You cannot pay for Dependent Care expenses from the Health Care FSA, nor can you pay for health care expenses from the Dependent Care FSA. 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 Care 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 Care 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:

1. require you to wait until the next annual open enrollment period to participate in the Health Care FSA;
2. require you to resume your original Health Care FSA election for the remainder of the plan year; or
3. permit you to make a new Health Care 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 Care FSA or revoke your existing election under the Health Care 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 Employee Benefits Office for further information about the ways in which you can continue to maintain your coverage under the Health Care FSA during FMLA leave. If, on the other hand, you wish to revoke your existing election (and coverage) under the Health Care 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 the Employee 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 Care FSA Works

The Health Care FSA allows you to set aside up to $2,500 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 Care 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 (including any grace period); 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 Care 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
- prescribed and over-the-counter medicines and drugs
- 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.)

Through 2010, the IRS had also determined that over-the-counter or non-prescription medicines and drugs are eligible expenses under this Plan even though they are not deductible. Effective January 1, 2011, however, over-the-counter nonprescription medications are no longer eligible expenses.

Note: Misuse of spending account funds is a violation of Internal Revenue Service regulations.

Eligible Dependent Expenses

Your Health Care 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 Care 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 Care 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);

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

**Tax Savings**

The Health Care 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 tax consultant to determine the impact, if any, that your participation in the Health Care 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 Care FSA. You may, however, take an itemized tax deduction for any expenses in excess of your Health Care 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 Nondiscrimination Requirements**

The Health Care FSA is required to satisfy certain nondiscrimination 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 Care 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 Care 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 Blue Cross and Blue Shield of Alabama Preferred Flex web site. 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. 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 Care 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 Care 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 Care 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 Care 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 Care 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 Care 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 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 do one or more of the following:

- you may ask the Preferred Blue Customer Service Center for further help; or,
• you may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Continuation of Your Health Care FSA

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

While on a Leave of Absence

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 the Employee 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 Care FSA for a certain length of time. However, before-tax funding will no longer be available, and your Health Care FSA contributions will be made on an after-tax basis. Refer to the next section, “Continuation of Coverage under COBRA.” The Employee 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 Care FSA is considered to be a health plan, COBRA entitles you or your spouse or dependent to extend participation in the Health Care 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 Care 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 Care 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 Care 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 Care FSA will stop on your last date of employment. However, expenses incurred after that date will not be eligible for reimbursement from the Health Care 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 Care 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 Care FSA. If claims are received and processed by us with incurred dates preceding the loss of coverage under the Health Care 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.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as the Health
Care FSA 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 the booklet explains some of HIPAA’s requirements. Additional information is contained in the Health Care FSA’s notice of privacy practices. You may request a copy of this notice by contacting your employer’s Benefits Office.

Disclosures of Protected Health Information to the Plan Sponsor: In order for your benefits to be properly administered, the Health Care FSA needs to share your protected health information with the plan sponsor (generally, your employer). Here are the circumstances under which the Health Care FSA may disclose your protected health information to the plan sponsor:

- The Health Care FSA may inform the plan sponsor whether you are enrolled in the Health Care FSA.
- The Health Care FSA 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 Health Care FSA. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The Health Care FSA 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 Health Care FSA.

Here 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 Health Care FSA’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 confidential 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 Health Care FSA any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of the booklet.
- The plan sponsor will allow you or the Health Care FSA 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 Health Care FSA must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the Health Care FSA 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 Health Care FSA 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 Health Care FSA 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 Health Care FSA or from any business associate when the plan sponsor no longer needs your protected health information to administer the Health Care FSA. 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: The Staff of the Human Resources Department of Southern Research Institute

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 violation like this, the plan sponsor will promptly report the violation to the Health Care FSA and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Security of Your Personal Health Information: Here are the 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 Health Care FSA, we (Blue Cross and Blue Shield of Alabama) have an agreement with the Health Care FSA 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 Health Care FSA, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the Health Care FSA 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 Health Care FSA.

DEPENDENT CARE FSA

Eligibility

All employees classified by the company as full-time, post doctoral, or regular part-time are eligible to participate in the Dependent Care FSA.

Your Enrollment Decision

Participation in the Dependent Care 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 Dependent Care 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 Dependent Care FSA during the first 30 days after their date of hire.

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 Dependent Care FSA 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 Dependent Care FSA is $2,500. There is a minimum annual contribution of $360.

**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 twice monthly 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 105 days (normally 3 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. Note that, unlike the case for the Health Care FSA, the grace period rules do not apply to the Dependent Care FSA.

Also note that the money you direct into your Dependent Care FSA can be used only to pay for eligible dependent care expenses. You can’t pay for health care expenses from the Dependent Care FSA, nor can you pay for dependent care expenses from the Health Care 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 Dependent Care 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);
- 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 be 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 Dependent Care FSA, 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 Dependent Care FSA Works**

The Dependent Care FSA 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 reimbursements 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 Dependent Care FSA, your spouse must work, be a full-time student or be disabled. In cases where a spouse is a student or disabled, Dependent Care FSA 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 Dependent Care FSA 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
o 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 online via the Internal Revenue web site or through your local IRS office.

What the Plan Doesn’t Cover

Certain dependent care expenses are not covered under the Dependent Care FSA. 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 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 Dependent Care FSA, you can help reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The Dependent Care 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.

IRS Requirements

The Dependent Care FSAs 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 Dependent Care 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 child care expenses that are reimbursed through the Dependent Care FSA. 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 Dependent Care FSA, and contact your personal tax advisor if you have any questions.

The company is required to report the amount you contributed to the Dependent Care FSA 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 Dependent Care FSA is designed to reimburse you for eligible dependent care expenses you already have paid. To receive Dependent Care FSA 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 FSA 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 FSA Request for Reimbursement will be reimbursed in full, up to the balance available in your Dependent Care FSA 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 Dependent Care 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 Dependent Care FSA;
- require you to resume your original Dependent Care FSA election for the remainder of the plan year; or
• permit you to make a new Dependent Care FSA election for the remainder of the plan year.

Your participation in the Dependent Care FSA 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.

**PREMIUM EXPENSE ACCOUNT**

Under this Plan, if you participate in the medical, dental, and/or vision insurance plans, you may elect to have your premiums withheld from your pay on a pre-tax basis. As with the Health Care and Dependent Care Flexible Spending Accounts, this tax exemption of your premiums will reduce your overall tax liability. To enroll for the Premium Expense Account, you simply complete the appropriate agreement form upon enrollment in any of the eligible insurance plans during the time you are initially eligible to enroll in those plans.

**Changes to Premium Expense Account Enrollment**

When you elect pre-tax withholding of your insurance premiums, federal tax law mandates that you may not make mid-year changes to your insurance enrollments within the calendar (tax) year unless you have a change in status as described earlier in this summary.

The Premium Expense Account enrollment, unlike the Health Care or Dependent Care Flexible Spending Accounts, does not require annual re-enrollment. Your enrollment, therefore, automatically renews each calendar year unless you actively disenroll before the start of the new year.

The cost of the premiums withheld under the Premium Expense Account are separate from the Health Care and Dependent Care Flexible Spending Accounts maintained under this Plan. As such, premium costs to not reduce or otherwise impact the maximum contributions allowed under each of these other components of this Plan.

**STATEMENT OF ERISA RIGHTS**

**Administrative Information**

ERISA safeguards your interests and those of your beneficiaries under the plan. As ERISA requires, this section provides additional information about your benefits, as well as a statement of your rights and protection under this law.

This description of the benefits available to you under the Preferred Blue Flexible Spending Plan constitutes a summary plan description under ERISA, to the extent applicable. It also constitutes the ERISA plan document, to the extent ERISA applies.

**Delegation of Discretionary Authority to Blue Cross and Blue Shield of Alabama**

The company has delegated to Blue Cross and Blue Shield of Alabama the discretionary responsibility and authority to determine whether expenses are due to be reimbursed under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with its provision of administrative services under the plan. Whenever Blue Cross and Blue Shield of Alabama makes reasonable determinations that are neither arbitrary nor capricious in its administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan and thereafter to judicial review to determine whether the determination of Blue Cross and Blue Shield of Alabama was arbitrary or capricious.

**Name and Type of Plan**

This plan is called the Flexible Spending Account Plan, which falls under the provisions of the Southern Research Institute
Health and Welfare Benefit Program. Under the definition of the Employee Retirement Income Security Act of 1974 (ERISA), the plan is classified as a welfare plan. The type of plan administration is employer administration.

**Plan Sponsor/Plan Administrator**

Southern Research Institute  
2000 Ninth Avenue South  
Birmingham, Alabama 35205-2708

Southern Research Institute is responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law. To the extent not delegated to Blue Cross and Blue Shield of Alabama, Southern Research Institute, as plan sponsor, has the discretionary authority to interpret and construe the terms of the plan.

**Funding**

The plan is funded through contributions made by participating employees. Your company pays all costs of administering the plan unless there have been forfeitures in that particular year. In that case, the forfeitures are applied to the cost of administering the plan.

**Legal Services**

Process in legal actions with respect to the plan should be directed to Blue Cross and Blue Shield of Alabama, Post Office Box 11586, Birmingham, Alabama 35202-1586, telephone number 1 800 213-7930. Service of legal process also may be made on Southern Research Institute as the plan administrator at 2000 Ninth Avenue South, Birmingham, AL 35205-2708.

**Payment of Benefits**

Blue Cross and Blue Shield of Alabama pays the benefits provided under the plan.

**Plan Records**

The plan's records are kept on a calendar year basis.

**Plan Identification Numbers**

The plan is identified by the following numbers under Internal Revenue Service (IRS) rules:

Employer Identification Number assigned by the IRS: 63-0288868

**Qualified Medical Child Support Orders**

Participants and beneficiaries may obtain from the plan administrator, without charge, a copy of the plan's procedures regarding qualified medical child support orders.

**Plan Continuance**

The company currently intends to continue the plan for active employees, but reserves the right to amend or terminate it at any time. The plan does not constitute a guarantee of employment either by your eligibility for or participation in the plan and does not interfere with the company's right to terminate your employment.

**Your Rights Under ERISA**

The benefits provided by the plan are covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA protects your rights under employee benefits plans. The law does not require a company to provide benefits, but ERISA sets standards for any benefits a company wishes to offer. ERISA also requires that you be given an opportunity to learn what
these benefits are and your rights to them under the law.

It is your right to know as much as possible about your benefits. This summary plan description is one way to keep you informed.

As a participant in the Preferred Blue Flexible Spending Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to the following rights:

**Receive Information About Your Plan and Benefits**

You may examine, without charge, at the office of the plan administrator (which will usually be your employer unless a different plan administrator is named above) 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) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

To the extent that COBRA applies, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

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

**Enforcing Your Rights**

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

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

**Assistance with Your Questions**
If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.