

**BANNER HEALTH
&
LABORATORY SCIENCES
OF ARIZONA**

Pre-Tax Plan

Pre-Tax Premium Plan
Health Care Flexible Spending Account
Dependent Care Flexible Spending Account

SUMMARY PLAN DESCRIPTION

Effective January 1, 2010

Banner Health Pre-Tax Plan

Banner Health Pre-Tax Plan (the Plan) was created to provide you with the ability to save on Federal withholding taxes by electing to set aside known eligible expenses for medical care and dependent day care. The Plan consists of three separate plans. The three plans are:

- (i) the Pre-Tax Premium Plan;
- (ii) the Health Care Flexible Spending Account (“HCFSA”); and
- (iii) the Dependent Care Flexible Spending Account (“DCFSA”).

The Plan is self-funded, which means premiums and claims are paid directly from accounts that are funded with your and Banner’s contributions. The Plan allows you to contribute a portion of your compensation on a “pre-tax” basis and use those contributions to provide yourself with “tax-free” benefits. This means that the cost of these benefits are deducted from your paycheck before Social Security and federal (and in most cases, state) income taxes. By paying for these benefits with “pre-tax” dollars instead of “after-tax” dollars, you reduce your taxable income by the amount you are contributing to the Plan. The Plan is intended to meet the requirements of Sections 105, 125 and 129 of the Internal Revenue Code. You make contributions to the Pre-Tax Premium Plan through payroll deductions.

Participation in the Plan may not benefit everyone. You must understand the operation of the Plan and the consequences of your election amounts before deciding to participate. Remember, participation can cost you money if you make improper elections or do not follow the rules of the Plan or the governing laws.

This Plan does not create a contract of employment. Your rights under the Plan are not vested, and Banner Health reserves the right to amend, change or end the Plan and any benefits described here for any reason. You can review the Plan documents by contacting Banner Plan Administration (BPA).

The benefits referred to in this Summary Plan Description (SPD) are those in effect January 1, 2010 for employees of Banner Health.

This Summary Plan Description (SPD) summarizes the benefits and important provisions of the Plan. If there is a conflict between a statement in this SPD and in the Master Health and Welfare Benefit Plan Document (Plan), the terms of the Plan shall control.

If, after referring to the information in this document, you still have a question concerning a plan benefit, talk to the Benefits Plan Representative at your facility, or call The Service Center at Banner Plan Administration at 800-684-2464 or 480-684-7070 in the Phoenix-metropolitan area.

The legal name, address and federal employer identification numbers are:

Banner Health

BPA Operations Compliance

525 W. Brown Road

Mesa, AZ 85201

800-684-2464

480-684-7070 (in the Phoenix-metropolitan area)

Employer Identification Number

45-0233470

Plan Identification Number

500

Asistencia para Miembros de Habla Hispana

Este folleto contiene un resumen en Ingles acerca de los derechos y beneficios de los empleados bajo el Plan de Beneficios de Salud Banner Health /Laboratory Sciences of Arizona. Si tiene dificultad entendiendo alguna parte de este folleto, por favor comuniquese con el Administrator del Plan durante las horas de trabajo:

Banner Health

BPA Operations Compliance

525 W. Brown Road

Mesa, AZ 85201

800-684-2464

480-684-7070 (in the Phoenix-metropolitan area)

Table of Contents

You can click on the title or page number in this Table of Contents and be brought directly to that page.

General Information	1
Q-1. Who can participate in the Plan?	1
Q-2. What do you mean by Plan Year?	1
Q-3. What do you mean by Period of Coverage?	1
Q-4. What is the “Annual Enrollment Period”?	1
Q-5. What are the maximum and minimum limits for the HCFSA and DCFSA?	1
Q-6. What are the three plans under the Banner Health Pre-Tax Plan?	1
Q-7. How do I enroll in the Plan?	1
Q-8. How do the Plans save me taxes?	2
Q-9. Can I change my election during the Plan Year?	3
<i>Life Events</i>	3
<i>Special Enrollment Rights</i>	3
<i>Qualified Change in Status</i>	4
<i>Significant Cost or Coverage Change</i>	5
<i>Medicare or Medicaid Entitlement</i>	5
<i>Qualified Medical Child Support Orders</i>	5
<i>Election Changes Imposed by the Plan</i>	6
Q-10. What happens if I terminate employment or lose eligibility during the Plan Year?	6
Q-11. How long will the Plan remain in effect?	6
Q-12. How will participating in the Plan affect my Social Security and other benefits?	6
Q-13. How does a Leave of Absence affect my benefits?	7
Q-14. What must I do to be reimbursed from my Flexible Spending Account (“FSA”)??.....	7
Q-15. What happens if my claim is denied?	7
Q-16. Is there a risk to me to participate in the HCFSA and/or DCFSA?.....	8
 Pre-Tax Premium Plan	 9
Q-17. What are Premium Payments?.....	9
Q-18. How are my Premium Payments paid?.....	9
 Health Care Flexible Spending Account.....	 9
Q-19. What is a Health Care Flexible Spending Account (HCFSA)?.....	9
Q-20. What do you mean by My HCFSA?.....	10
Q-21. How are my contributions to my HCFSA calculated?	10
Q-22. What are the minimum and maximum HCFSA limits I can elect?	10
Q-23. Why does the IRS care what I put in or take out of my HCFSA?.....	10
Q-24. How much can I request to be reimbursed from my HCFSA at any one time?	10
Q-25. What are considered eligible Medical Care Expenses?.....	11
<i>Eligible:</i>	11
<i>Exclusions:</i>	11
Q-26. What must I do to be reimbursed from my HCFSA?	2
Q-27. What does it mean to “incur a medical care expense”?.....	4
Q-28. What if my Medical Care Expenses are less than my Plan Year election?	4
Q-29. Will I be taxed on the HCFSA Reimbursements I receive?	4
Q-30. What are my COBRA and HIPAA rights with Respect to my HCFSA?	4
<i>COBRA Rights</i>	4
<i>HIPAA</i>	4

Dependent Care Flexible Spending Account.....	4
Q-31. What is a Dependent Care Flexible Spending Account (“DCFSA”)?.....	4
Q-32. What do you mean by my DCFSA?	5
Q-33. How are my contributions to my DCFSA calculated?	5
Q-34. What are the minimum and maximum DCFSA limits that I can elect?	5
Q-35. Why does the IRS care what I put in or take out of my DCFSA?.....	5
Q-36. How much can I request to be reimbursed from my DCFSA at any one time?	6
Q-37. What are considered eligible Dependent Care Expenses?.....	6
<i>Eligible:</i>	6
<i>Exclusions:</i>	8
Q-38. What must I do to be reimbursed from my DCFSA?	8
Q-39. What does it mean to incur a Dependent Care Expense?	9
Q-40. What if my Dependent Care Expenses are less than my Plan Year election?.....	9
Q-41. Will I be taxed on the DCFSA Reimbursements I receive?	9
Q-42. Can I still claim the Dependent Care Credit on my federal income tax?	9
Q-43. What is the Dependent Care Credit?	9
Q-44. Which way is better, to take a Tax Credit or use the DCFSA?	9
General Provisions	10
Filing a Claim	10
If A Claim Is Denied	10
Plan Sponsor Appeal.....	10
Timelines Applicable to the Formal Appeal Process	11
COBRA: Continuation of Coverage Option.....	11
Your Rights under ERISA	18
Summary Plan Description	19

General Information

Q-1. Who can participate in the Plan?

Banner Health employees who are regularly scheduled to work 32 hours or more a pay period and have a FA/FI, PA/PI or WA/WI status code.

Q-2. What do you mean by Plan Year?

The Plan Year is the 12-month period from January 1 through December 31.

Q-3. What do you mean by Period of Coverage?

A Period of Coverage is all or the portion of the Plan Year that begins with the effective date of your benefits or any change in benefits due to a Life Event (see Q-9below).

Q-4. What is the “Annual Enrollment Period”?

The Annual Enrollment Period is the time established by Banner Health before each Plan Year when you are allowed to make benefit elections for the following Plan Year. This is typically a two-week period during the 4th Quarter of each year. You will be notified each year of the Annual Enrollment Period.

Q-5. What are the maximum and minimum limits for the HCFSA and DCFSA?

The maximum that you may contribute to and be reimbursed from each of the HCFSA and DCFSA is \$5,000 during any Plan Year. For details on the specific reimbursement requirements of each arrangement, see the detailed discussion for each plan below.

Q-6. What are the three plans under the Banner Health Pre-Tax Plan?

The Plans include the following:

Pre-Tax Premium Plan— permits you to pay your share of premiums (contributions for the cost of coverage) for the Banner Medical, Dental, Pharmacy and Vision Plans with pre-tax dollars. (See Q-17 for more information.) You are automatically enrolled in the **Pre-Tax Premium Plan** when you enroll for the Banner Health Medical, Pharmacy, Dental or Vision Plan.

Health Care Flexible Spending Account (“HCFSA”)—also called a medical expense reimbursement plan—permits you to pay for your qualified Medical Care Expenses (that are not paid or reimbursed by another type of coverage) with pre-tax dollars. (See Q-19 below for more information.) You must enroll each year to participate in **the HCFSA**.

Dependent Care Flexible Spending Account (“DCFSA”)—also called a dependent care assistance plan—permits you to pay for your qualified Dependent Care Expenses with pre-tax dollars, such as day-care or elder-care, that allow you to work. (See Q-31 below for more information) You must enroll each year to participate in **the DCFSA**.

Q-7. How do I enroll in the Plan?

When you enroll in the Banner Health Medical, Pharmacy, Dental or Vision Plans, you are automatically enrolled in the Pre-Tax Premium Plan.

You have several options for enrolling in the HCFSA or DCFSA:

- (a) As a new hire, you may enroll within 31 days of your hire date. Your coverage becomes effective the first of the month following your hire date. However, your effective date will be your hire date if you are hired on the first of the month.

- (b) During the Annual Enrollment Period each year.
- (c) When you have a Life Event during the Plan Year (see Q-9 below).

Enrolling in the Plans is easy. During your initial eligibility period as a new hire or during the Annual Enrollment Period, you will receive an Enrollment Guide along with your cost of coverage. You can make your coverage elections on the Internet through the Banner Benefit Administration System at www.buckhrsolutions.com/banner or by calling the Service Center at Banner Plan Administration at 800-827-2464 or 480-684-7070 in the Phoenix-metropolitan area and a Banner Benefits Service representative will assist you with enrolling. After enrollment, you will receive confirmation of your benefit elections from BPA or you may print your own confirmation from the Internet.

If there is a Life Event that allows you to change your Pre-Tax Premium Plan, HCFSA or DCFSA election, you should contact the Service Center at Banner Plan Administration at 800-827-2464 or 480-684-7070 in the Phoenix-metropolitan area.

If you do not enroll in the HCFSA or DCFSA within the specified time period, you must wait until the next Annual Enrollment Period unless you have a Life Event during the Plan Year.

Q-8. How do the Plans save me taxes?

You save both Federal and FICA (Social Security) taxes by participating in the Plan. Following is an example of the tax savings you might experience as a result of participating in the Pre-Tax Plan.

	<u>Without</u> Pre-Tax Plans Per Year	<u>With</u> Pre-Tax Plans Per Year
Annual Family Income	\$80,000	\$80,000
Health Plan Premium (\$119/Month)	\$0	(\$1,428)
Pharmacy Standard Plan (\$41/Month)	\$0	(\$492)
Dental Comprehensive (\$77/Month)	\$0	(\$924)
Deductibles/Copays for Medical Reasons	\$0	(\$1,375)
Day Care Expenses (\$300/Month)	\$0	(\$3,600)
Taxable Income	\$80,000	\$72,181
Taxes (Federal and FICA 30%)	\$24,000	\$21,654
Total After Taxes	\$56,000	\$50,527
Health Plan Premium (\$119/Month)	(\$1,428)	
Pharmacy Standard Plan (\$41/Month)	(\$492)	
Dental Comprehensive (\$77/Month)	(\$924)	
Deductibles/Copays for Medical Reasons	(\$1,375)	
Day Care Expenses (\$300/Month)	(\$3,600)	
Net-Take Home Pay with no Pre-Tax	\$48,181	\$50,527
Additional Take Home Pay with Pre-Tax		\$ 2,346

Example: Suppose that you are married, have one child and are a non-tobacco user. You and your spouse both work and have a combined annual income of \$80,000. Assume that you elect Employee & Family coverage under the one of the Banner Medical Plans at a cost of \$119 a month, the a Pharmacy Plan at a cost of \$41 a month, and the Dental Plan at a cost of \$77 a month, and that your total annual deductibles and copays are \$1,375 and your total annual day care expenses are \$3,600. The chart below shows how you can increase your take home pay by using the Pre-Tax Plan to pay for these expenses.

Q-9. Can I change my election during the Plan Year?

Once you elect to receive or decline coverage, you generally cannot change your elections until the following Annual Enrollment Period. However, as answered in Q-7, under certain circumstances you may be able to change your elections mid-year. You must make your new elections within 31 days of the event allowing the change and the change must be consistent with the event. The circumstances that may permit changes in your elections are the following:

Life Events:

- HIPAA Special Enrollment
- Change in Status
- Significant Cost or Coverage Change
- Medicare or Medicaid Entitlement
- Qualified Medical Child Support Order

The chart below shows which Plan options you may change as a result of a certain Change Event:

CHANGE EVENT	Change Permitted?		
	Pre-Tax Premium Plan	HCFSAs	DCFSAs
HIPAA Special Enrollment	Yes	No	No
Change in Status	Yes	Yes	Yes
Significant Cost or Coverage Change	Yes	No	Yes
Medicare or Medicaid Entitlement	Yes	No	No
Qualified Medical Child Support Order	Yes	No	No

Any change must be consistent with the reason the change was permitted. A change in your election under these circumstances will be effective the first day of the month following the later of the date the election change is completed or the date the triggering event occurs. If the event is the birth or adoption of a child (including placement of a child for adoption), however, the election change will take effect on the date of the birth or adoption (or placement for adoption).

Special Enrollment Rights

A special enrollment period is a time other than the annual enrollment period when eligible employees and their eligible dependents can enroll in the Plan. Special enrollments in your Pre-Tax Premium Plan elections for Banner Health Medical, Dental, Pharmacy and Vision Plans are allowed if one of the following events occurs:

- You acquire a new dependent due to marriage, birth, adoption, or placement for adoption

- You declined coverage under a Banner Health plan (either initially or during a subsequent open enrollment period) because you were covered under another group health care plan or health insurance coverage, and you then lose that coverage for any of the following reasons:
 - You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause)
 - Employer contributions toward the other group health plan coverage terminate, or
 - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
 - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment
 - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area
 - In the case of an group HMO, loss of coverage because you no longer reside or work in the service area; provided that no other benefit package is available to you
 - When you or your dependent incurs a claim that meets or exceeds a lifetime limit on all benefits, or
 - When a plan no longer offers any benefits to your class of similarly situated individuals.
- Effective April 1, 2009:
 - You or your dependent becomes ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated, or
 - You or your dependent becomes eligible for a premium assistance subsidy for the plan under Medicaid or the state child health plan.

You must request a change in coverage within 31 days of the special enrollment event, subject to the following exceptions:

- If the event is reaching a lifetime limit on benefits under another group health plan, then the request must be made within 31 days of the date a claim is denied under the other group health plan due to the operation of a lifetime limit on all benefits, or
- If the event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premium assistance subsidy for the plan under Medicaid or the state child health plan, then the request for a change in coverage must be made within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Qualified Change in Status

If you experience a qualified change in status that affects eligibility, you may change your elections under the Plan. Changes in status include the following:

- Legal marital status – any event that changes your legal marital status, including marriage, death of a spouse, divorce, or annulment.
- Number of dependents – any event that changes the number of your dependents, including birth, adoption, placement for adoption, divorce or death of a dependent.

- Employment status and work schedule – any event in which employment begins or ends for you or your eligible dependent; the gain or loss of eligibility due to a change in full-time to part-time status or vice versa.
- Dependent status – any event which causes your unmarried eligible dependent to satisfy or cease to satisfy eligibility requirements due to age, student status, or similar circumstances under the Plan which you receive coverage.
- Residence or worksite – any event that where you or your eligible dependent transfer place of residence or work site that creates a change in your health plan coverage. (Example – Banner Choice Plus is not offered in all Banner Communities.)

You must request a change in coverage within 31 days of the date of the change in status event.

Significant Cost or Coverage Change

You may also change your Pre-Tax Premium Plan and DCFSA (but not your HCFSA) coverage election under the plan midyear if:

- The cost of your current coverage option significantly increases or significantly decreases
- An event occurs that significantly curtails coverage or causes you to lose coverage under your current coverage option
- A coverage option is added or is significantly improved under the plan during the year, and you are eligible for such option
- You, your spouse/domestic partner, or your eligible dependent loses coverage under any group medical coverage sponsored by a governmental or educational institution, or
- The change corresponds with a change made by you or your dependent under another employer's plan in the following circumstances:
 - If the annual enrollment period under the other plan occurs at a different time of year than annual enrollment under the plan, or
 - If the other employer's plan allows you or your dependent to change elections due to the reasons described in this section (special enrollment, change in status, significant cost or coverage changes, and QMCSO).

You must request a change in coverage within 31 days of the significant cost or coverage change.

Medicare or Medicaid Entitlement

If you or your spouse, domestic partner or dependent enroll in or lose coverage under Medicare (Part A or B) or Medicaid, you may change your Pre-Tax Premium Plan election accordingly. The request for a change in coverage must be made within 31 days of the change in your Medicare or Medicaid coverage.

Qualified Medical Child Support Orders

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders from a state court or state administrative agency requiring a partner to provide medical support to a child, for example, in cases of legal separation or divorce.

Election Changes Imposed by the Plan

Although it is unlikely that your elections and benefits under the Plan will be affected by the numerous nondiscrimination tests that apply to them under the Internal Revenue Code of 1986 (the “Code”), you should know that there are a number of legal limitations that apply to benefits under the Plan. The Plan Administrator reserves the right to modify any benefit elections by the amount necessary to allow the Plan to satisfy any applicable nondiscrimination requirements. If these nondiscrimination tests ever apply to you, the Plan Administrator will inform you of the effect on your Plan elections and benefits.

Additionally, if the cost of premiums for the Banner Medical, Dental, Pharmacy or Vision Plans increases or decreases during a period of coverage, and you are required to make a corresponding change in payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in your elective contributions to the Plan.

Q-10. What happens if I terminate employment or lose eligibility during the Plan Year?

If your employment with Banner Health terminates or you no longer meet the requirements to participate in the Plan during the Plan Year, you will not be able to continue making contributions to the Plan. Your coverage shall automatically terminate on the earliest of the following dates:

- the last day of the month in which you terminate employment,
- the last day of the month in which employment classification changes to an ineligible position,
- the last day of the month you elect to be terminated from the Plan,
- the last day of the month required contributions cease,
- the date of termination of the Plan.

If you are rehired or become eligible within 31 days of your date of termination of coverage, within the same Plan Year and without any other intervening event that would permit a mid-year change in election, you will automatically be reinstated for the same elections that were in effect before your coverage terminated. Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion, permit you to change your elections based on the facts and circumstances surrounding your reemployment. Depending on the nature of the election change, you may be required to pay your premiums on an after-tax basis until the next Plan Year.

If you are rehired more than 31 days after your date of termination, you may make new benefit elections as if you were a new hire.

Q-11. How long will the Plan remain in effect?

Although Banner Health expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason by a written action adopted by its Board of Directors or its designee. It is also possible that future changes in state or federal tax laws may require that the Plan be amended.

Q-12. How will participating in the Plan affect my Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Q-13. How does a Leave of Absence affect my benefits?

If you go on a Paid Leave of Absence that allows you to continue your benefits, your contributions to the Plan will continue and your participation in the Plan will remain unchanged for as long as you pay the associated premiums.

If you go on an Unpaid Leave of Absence longer than 31 days, your participation under (all three components of) the Pre-Tax Plan will cease. When you return, you may make new elections for coverage. This applies to all benefits except the Flexible Spending Accounts which cannot be less than the amount previously paid to you from this account. If an Annual Enrollment has taken place, then you may elect up to the maximum of the Plan for the remainder of the new plan year.

If your Leave of Absence is less than 31 days, you will continue in the Plan and will be required to make up any missed pre-tax contributions upon your return to work, unless there has been a Life Event (See Q-9) that allows you to change the election that was in effect before your leave.

Q-14. What must I do to be reimbursed from my Flexible Spending Account (“FSA”)?

At the time you elect to participate in the HCFSA and/or DCFSA, you have the option of choosing a Convenience Card that is linked directly to your Flexible Spending Account(s). If you don't choose the Convenience Card option, you will be required to file a claim for each eligible Medical Care or Dependent Care expense. If you choose this option, you can be reimbursed either by having a check mailed to your home or a direct deposit made to your personal checking or savings account.

You can use the Convenience Card for eligible expenses at approved providers that accept signature based debit cards. You should always obtain a detailed receipt for your transactions, as the Claims Administrator will ask you to provide a detailed receipt or bill showing your financial responsibility for the services provided.

When you incur an expense that is eligible for payment, and you do not have or choose not to use your Convenience Card, you can submit a paper claim to the Administrator by using the *Reimbursement Request Form*. These forms are available online at www.discoverybenefits.com or by calling the Claims Administrator at **866-451-3399**. You may also be required to provide documentation showing that you paid or are liable to pay for the eligible expense. You may mail your Reimbursement Request to the Claims Administrator at the address on the form or, to expedite the payment of your claims, fax the Reimbursement Request Form and all the necessary receipts to 866-451-3245.

You will have 90 days from the end of the Plan Year in which to submit a claim for reimbursement from your Health Care Flexible Spending Account and/or your Dependent Care Flexible Spending Account for an eligible expense that was incurred during the Plan Year in which your contributions were made.

You will be notified, in writing, if any claim for benefits is denied. (See Q-15.)

Q-15. What happens if my claim is denied?

If a claim for reimbursement under the HCFSA or DCFSA Plans is wholly or partially denied or you are denied a benefit under the Plan, then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by Discovery Benefits, Inc. within 30 days of the date your claim is received. This time period may be extended for an

additional 15 days for matters beyond the control of the Administrator. When the claim is submitted incomplete, the notice of an extension will specifically describe the required information. You will then have 45 days from receipt of the notice to provide the information. The time for a decision on your claim will be suspended until the specified information is provided.

Notification of a denied claim will detail:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- Appropriate information on the steps to be taken if you wish to appeal the decision, including your right to submit written comments for consideration and your right to review (upon request and at no charge) relevant documents and other information.

If your claim is denied in whole or part, you may request review upon written application to Banner Plan Administration (BPA). Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. Your written appeal should state the reasons you feel your claim should not have been denied. It should include any additional facts and/or documents you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by BPA or other entity designated in the Plan in a reasonable time, not to exceed 60 days, after BPA receives your request for review. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination. The review will include:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information; if an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring a civil action under ERISA Section 502(a) after the issuance of a final adverse benefit determination on appeal.

Except as required by law, the review decision is final and binding on all parties. You must comply with and exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the Plan under Section 502(a) of ERISA.

Q-16. Is there a risk to me to participate in the HCFSA and/or DCFSA?

There is a financial risk if you over-estimate your expenses and elect to contribute an amount to the HCFSA or the DCFSA that is higher than the eligible expenses that you actually incur and can be reimbursed from your FSAs for the Plan Year.

The IRS has rules governing these plans that are important for you to understand. Under these pre-tax plans, you are allowed to reduce your taxable income by the amount you elect to contribute to the Plans. These amounts are then credited to your HCFSA and/or DCFSA and used to reimburse you for eligible expenses as explained in this SPD. If the rules are violated, you will not be able to take advantage of the pre-tax benefits.

If you over-estimate and do not have the eligible expenses to claim the contributions made to your account, you will forfeit any unused amounts. This is referred to by the IRS as the "Use-It or Lose-It" rule. If you under estimate, you lose only the tax savings that you could have realized, but there is no loss of income to you. You end up paying for the expenses you would have had anyway, but with your regular after-tax income.

For these reasons it is very important that you carefully estimate your medical care and dependent care expenses each year. During the Annual Enrollment period you are allowed to change your benefit elections. Some of your benefit elections under the Pre-Tax Premium portion of this Plan, such as your Banner Health Medical, Pharmacy, Dental and Vision Plans automatically roll over each Plan Year unless you affirmatively change your benefit elections. However, you must affirmatively enroll in each FSA each year. You must estimate the amount of money that you think you will need in your HCFSA and/or DCFSA for each Plan Year. Your election cannot change during the Plan Year unless you have a Life Event (See Q-9) that allows you to make a change.

Forfeited amounts will be used by the Plan to offset reasonable administrative expenses, or as otherwise permitted by IRS rules.

Pre-Tax Premium Plan

Q-17. What are Premium Payments?

Premium Payments under the Plan are your share of the cost for the coverage you elect under the Banner Health Medical, Pharmacy, Dental and Vision Plans. You will automatically be enrolled in the Pre-Tax Premium Plan. This means that the contributions you make for your, your spouse's or your tax-qualified dependent's benefits will be with pre-tax dollars, which saves you money by reducing the taxes you pay.

Q-18. How are my Premium Payments paid?

If you elect coverage under the Banner Health Medical, Pharmacy, Dental or Vision Plans, you will automatically be enrolled in the Pre-Tax Premium Plan. The amount of your contributions will automatically be deducted from your paycheck before the taxes on your income are calculated. These amounts are then paid by Banner Health to cover your share of the cost of the Banner Health Plans you elect.

Health Care Flexible Spending Account

Q-19. What is a Health Care Flexible Spending Account (HCFSA)?

An HCFSA allows you to use pre-tax dollars to pay for eligible medical (includes dental, vision and pharmacy) care expenses that are not reimbursed by any health care coverage you may have. These accounts are allowed under section 125 of the Internal Revenue Code and are also referred to as "cafeteria plans" or "125 plans."

You may elect to contribute a portion of your pay on a pre-tax basis to an HCFSA before the beginning of any Plan Year, within 31 days of hire or in connection with a Life Event (See Q-9). Your pay will be reduced by the amount of your contributions from each of your paychecks through the Banner Health Payroll System before the taxes on your income are calculated. This amount is then credited to your HCFSA. Contributions made to this account can be used to reimburse you for eligible expenses.

The expenses that may be reimbursed from this account must be eligible expenses as defined by the IRS. These expenses are listed below in Question 25 and include your out-of-pocket expenses for medical care coverage such as deductibles, office visit copays and some over-the-counter drugs.

Q-20. What do you mean by My HCFSA?

When you elect an HCFSA, an account is set up in your name to keep a record of your contributions and the expense reimbursements you have claimed. Your HCFSA is merely a recordkeeping account and does not earn interest.

Q-21. How are my contributions to my HCFSA calculated?

When you enroll in an HCFSA, you specify the amount that you want to contribute with your salary reduction election for the Plan Year. This amount is divided by the number of pay periods left in the Plan Year, which is also referred to as the “Period of Coverage.” Your contributions will be deducted each pay period during your entire Period of Coverage. If, however, you have a Life Event (See Q-9), you may be allowed to change your election.

Q-22. What are the minimum and maximum HCFSA limits I can elect?

The most you can contribute or be reimbursed for any Plan Year is \$5,000. The minimum amount you can contribute is \$100 for any Plan Year.

Q-23. Why does the IRS care what I put in or take out of my HCFSA?

The IRS defines eligible medical care expenses under the IRS Code Section 213 ([IRS Publication 502](#)) that may be reimbursed under this type of plan or used as a deduction for income tax purposes. You cannot, however, be reimbursed from the Plan for any expenses you claim as a deduction on your income tax return. To file for a tax deduction on your tax return, the current IRS criteria require that you have total eligible medical expenses in excess of at least 7.5% of your adjusted gross income. The HCFSA only requires that a minimum of \$100 be elected by you for the Plan Year.

Q-24. How much can I request to be reimbursed from my HCFSA at any one time?

You can request to be paid the full amount of your annual election at any time during the Plan Year. The full amount you have elected, minus any reimbursements already made, is available for reimbursement of your eligible medical care expenses (see Q-25 below) that are incurred in the same Plan Year, regardless of the amount that you have contributed at the time.

For example – You elected an HCFSA with an annual amount of \$1,000 effective January 1. On March 1, you have an eligible medical care expense for the full \$1,000. Even though you have only contributed for January and February, you can submit and be reimbursed for the full \$1,000. The deductions from your pay will continue for the remainder of the Plan Year, but you will not be able to claim reimbursement for any additional expenses since you have received the total amount you elected to contribute to the Plan.

Q-25. What are considered eligible Medical Care Expenses?

Expenses are considered eligible for reimbursement from an HCFSA if they have been incurred for the diagnosis, cure, mitigation, treatment or prevention of illness or disease or treatment affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. *Expenses solely for cosmetic reasons generally are not eligible expenses for medical care.* Also, expenses that are merely beneficial to one's general health (for example, health spas) are not expenses for medical care. A partial list of eligible expenses and exclusions are shown below. Section 213(d) of the Internal Revenue Code governs what is and is not eligible. Please see [IRS Publication 502](#), Medical and Dental Expenses, for a more detailed list. These lists are only a guide as to the types of expenses that can be considered for reimbursement.

Eligible:

- Acupuncture
- Ambulance
- Artificial limbs
- Artificial teeth
- Birth control
- Braces
- Chiropractor's fees
- Christian Science Practitioners fees
- Contact Lenses
- Contact Lens Solution
- Crutches
- Deductibles, coinsurance, and copayments under Banner's or another group health plan
- Dental fees (not considered cosmetic)
- Diagnostic fees
- Eyeglasses
- Eye Exams
- Guide dog
- Hearing Aids
- Hearing Aid Batteries
- Hospital services
- Immunizations
- Insulin
- Laboratory fees
- Medical services
- Nursing services
- Operations
- Osteopath
- Over-the-counter medications (limited)
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychoanalyses
- Psychologist
- Sterilization
- Transplants (organ)
- Wheelchair
- X-ray

Exclusions:

- premiums for any medical care coverage, including premiums for COBRA coverage, AD&D coverage, disability insurance, or another employer's group health plan;
- long-term care insurance premiums or services;
- procedures considered to be strictly cosmetic surgery that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- the salary expense of a nurse to care for a healthy newborn at home;
- funeral and burial expenses;
- household and domestic help;
- massage therapy; unless prescribed by physician for a specific medical condition home or automobile improvements;

- custodial care;
- costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods unless the availability of medical care in the school is a principal reason for sending the child to the school;
- health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity;
- social activities, such as dance lessons (even though recommended by a physician for general health improvement);
- bottled water;
- maternity clothes;
- diaper service or diapers;
- cosmetics, toiletries, toothpaste, etc.;
- vitamins and food supplements, unless prescribed by a physician for a specific condition;
- uniforms or special clothing, such as maternity clothing;
- automobile insurance premiums;
- marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician; and
- any item that does not constitute “medical care” under [Code § 213](#).

For more information about what items are and are not eligible medical care expenses you may contact the Claims Administrator at **866-451-3399** or visit their Website at www.discoverybenefits.com.

Q-26. What must I do to be reimbursed from my HCFSA?

At the time you elect to participate in the HCFSA you have the option of choosing a Convenience Card (Debit Card) that is linked directly to your HCFSA. If you do not choose the Convenience Card option, you will be required to file a claim for each eligible medical care expense. If you choose to file claims, you can be reimbursed either by a check being mailed to your home or having a direct deposit reimbursement to your personal checking or savings account.

You can use the Convenience Card for eligible expenses at approved providers that accept signature based debit cards. You should always obtain a detailed receipt for your transactions, as the Claims Administrator will ask you to provide a detailed receipt or bill showing your financial responsibility for the services provided.

For a charge to a debit card that is treated by the FSA Administrator as conditional, pending substantiation, you must provide additional independent third-party information describing the goods or services, the date of the service or sale, and the amount of the transaction. If you do not substantiate your claim in a form satisfactory to the FSA Administrator, the FSA Administrator will take the following steps with respect to the unsubstantiated claims:

- *Deactivate Card.* The FSA Administrator will deactivate your Flex Convenience Card. You may continue to request payments or reimbursements of medical expenses from the FSA by submitting receipts for reimbursement. Your Flex Convenience Card will be reactivated when you substantiate your pending claims.
- *Request Repayment.* The FSA Administrator will request that you repay the FSA in the amount of the unsubstantiated claim(s).
- *Offset.* If an unsubstantiated amount remains outstanding, the FSA Administrator will apply a claims substitution policy and reduce a later claim for a substantiated expense within the same coverage period by the amount of the improper payment.

- *Treat as other Business Indebtedness.* If amounts still remain unsubstantiated and outstanding, Banner Health will treat the improper payment as it would treat any other business indebtedness and take the same steps it would take to collect an equivalent business debt.
- *Reclassify as Taxable Earnings.* Banner Health will reclassify the amount of your unsubstantiated FSA claims as taxable earnings.

When you incur an expense that is eligible for payment, and you do not have or choose not to use your Convenience Card, you can submit a paper claim to the Administrator by using the *Reimbursement Request Form*. These forms are available online at www.discoverybenefits.com or by calling the Claims Administrator at **866-451-3399**. Supporting documentation must accompany all FSA reimbursement requests. IRS Guidelines require the submission of third-party documentation, which includes:

- Date of service
- For whom service was provided
- Name of person/group providing services
- Description of service
- Total cost of service

Acceptable documentation generally includes an Explanation of Benefits (“EOB”) from your medical or dental insurance carrier and/or a receipt from your provider detailing the date of service, description of service and total cost of the service. Canceled checks, credit card receipts or statements, or balance forward statements are not acceptable forms of documentation. Reimbursement of over-the-counter medications and supplies may require copies of a receipt showing date of purchase, name of item and the amount paid for the item.

The request must also include a written statement from you that the expense has not been reimbursed and is not reimbursable under any other plan, policy or arrangement. Signing and submitting to the Claims Administrator the Reimbursement Form, which includes the required statement that the expense has not been reimbursed and is not reimbursable under any other plan satisfies this requirement.

Under your HCRA, you can be reimbursed up to the amount you elected to contribute for a Plan Year less any amounts already paid to you that Plan Year, regardless of the amount you have contributed to the FSA as of the time you submit the claim. Under your DCRA, you can be reimbursed only up to the balance in your FSA at the time payment is made.

You may mail your Reimbursement Request to the Claims Administrator at the address on the form or, to expedite the payment of your claims, fax the Reimbursement Request Form and all the necessary receipts to **866-451-3245**.

You will have 90 days from the end of the Plan Year in which to submit a claim for reimbursement from your Health Care Flexible Spending Account for an eligible medical expense that was incurred during the Plan Year in which your contributions were made

You will be notified, in writing, if any claim for benefits is denied. (See Q-15)

Q-27. What does it mean to “incur a medical care expense”?

A medical care expense is *incurred* when the service is provided, not when it is paid for. Note that if you have pre-paid for the expense but the services have not yet been provided, then the expense has not been incurred for purposes of filing an HCFSA claim. This is often the case for orthodontics. The dental office may offer the option of paying in one lump sum when the braces are inserted; however this is not currently an eligible expense under the Banner Medical Pre-Tax Plan.

Further, you cannot be reimbursed for any expenses incurred before your enrollment in the Plan becomes effective or after the termination of your participation in the Plan.

Q-28. What if my Medical Care Expenses are less than my Plan Year election?

As described above, this is controlled by IRS rules. If your expenses are less than the amount you elect to contribute at the beginning of year, you will have to forfeit any used amounts as described in Q-16. This is often referred to as the “Use or Lose” clause. This is why you should never over estimate what you expect to spend in any year. It is better to under estimate than over estimate.

Q-29. Will I be taxed on the HCFSA Reimbursements I receive?

You will not be taxed on your HCFSA reimbursements when you receive them from the Plan. However, Banner Health cannot guarantee that your HCFSA participation will not be questioned by the IRS during an audit of your taxes. Ultimately, you are responsible for determining whether each payment you receive from the Plan is excludable for tax purposes, and for maintaining proper records of the expense.

Q-30. What are my COBRA and HIPAA rights with Respect to my HCFSA?

COBRA Rights. You have a right to continue your HCFSA coverage if there is a loss of coverage under the plan as a result of a COBRA Qualifying Event and the balance in your HCFSA account as of the date of your Qualifying Event exceeds the amount of your reimbursable expenses submitted to the HCFSA as of that time. You may continue making your contributions to the Plan on an after-tax basis until the end of the Plan Year that contains the Qualifying Event. This will allow you access to the unused funds in your HCFSA as long as you continue to make your contributions. See the section “Continuation of Coverage Option” for additional details.

HIPAA Privacy Rights. Under HIPAA, Banner Health and the Claims Administrator are required to take steps to ensure that certain “protected health information” (“PHI”) is kept confidential.

If you have any questions about the Plan, you should contact the Claims Administrator, Discovery Benefits, Inc. through their Website www.discoverybenefits.com or by phone at 866-451-3399.

Dependent Care Flexible Spending Account

Q-31. What is a Dependent Care Flexible Spending Account (“DCFSA”)?

A DCFSA allows you to use pre-tax dollars to pay eligible dependent care expenses that are incurred to enable you and your spouse, if applicable, to work or look for work. Your spouse is treated as working during any month he or she is a full-time student or is mentally or physically incapable of self-care. This benefit is allowed under the [IRS Code 129](#).

You may elect to contribute a portion of your pay on a pre-tax basis to a DCFSA before the beginning of any Plan Year, within 31 days of hire or in connection with a Life Event (See Q-9). Your pay will be reduced by the amount of your contributions from each of your paychecks through the Banner Health Payroll System before the taxes on your income are calculated. This amount is then credited to your DCFSA. Contributions made to this account can be used to reimburse you for eligible expenses. The expenses that may be reimbursed from this account must be eligible expenses as defined by the IRS.

Q-32. What do you mean by my DCFSA?

When you elect a DCFSA, an account is set up in your name to keep a record of your contributions and the expense reimbursements you have claimed. Your DCFSA is merely a recordkeeping account and does not earn interest.

Q-33. How are my contributions to my DCFSA calculated?

When you enroll in a DCFSA, you specify the amount that you want to contribute for the Plan Year. This amount is divided by the number of pay periods left in the Plan Year, which is also referred to as the "Period of Coverage." Your contributions will be deducted each pay period during your entire Period of Coverage. If, however, you have a Life Event (See Q-9), you may be allowed to change your election.

Q-34. What are the minimum and maximum DCFSA limits that I can elect?

The most you can contribute or be reimbursed in any Plan Year is \$5,000. The minimum amount you can contribute is \$100 for any Play Year.

The amount you elect to contribute for any year is subject to additional limits under [Internal Revenue Code § 129](#). You may contribute \$5,000 for a calendar year if you:

- are married and file a joint return;
- are married, but are legally separated from your spouse under a decree of divorce or of separate maintenance;
- are married and file a separate return if:
 - you maintain as your home a household that is for more than half of the taxable year the principal residence of a qualifying individual;
 - you furnish over half the cost of maintaining such household during the year; and
 - your spouse maintains a separate residence for the last six months of the calendar year.
- are single; or
- are the head of the household for tax purposes.

If you are married and live with your spouse but you file a separate federal income tax return, then the maximum DCFSA benefit that you may elect is \$2,500 for a calendar year. The above maximum (\$5,000 or \$2,500 for a calendar year, as applicable) applies to the amount you elect under this Plan combined with any amount contributed to a plan available to your spouse. The maximum amount may be further limited because of other limitations, as described in Q-37 (for example, reimbursement cannot exceed the total amount of you or your spouse's earned income for the Plan Year).

Q-35. Why does the IRS care what I put in or take out of my DCFSA?

The IRS defines eligible dependent care expenses under the [IRS Code Section 129](#) that may be reimbursed under this type of plan or used as a deduction for income tax purposes. You cannot, however, be reimbursed from the Plan for any expenses you claim as a deduction on your income tax return.

Q-36. How much can I request to be reimbursed from my DCFSA at any one time?

The amount that is available for reimbursement of eligible Dependent Care Expenses at any one time during the Plan Year is equal to the amount of your current contributions minus any reimbursements already made in the same Plan Year. The money must be credited to your DCFSA before you can be reimbursed.

Q-37. What are considered eligible Dependent Care Expenses?

Dependent Care Expenses are employment-related day care expenses you have for a Dependent who meets the requirements to be a *Qualifying Individual*, as defined below. The following list is meant to provide a guideline for you to determine if an expense is eligible for reimbursement:

Eligible:

- Day care
- Nursery school
- After-school care programs
- Day camp
- Elder care
- Home health care worker

All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each Dependent for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
 - An individual that is your “qualifying child” under Code Section 152 as modified for dependent care purposes and who is under the age of 13, or who is age 13 or over and physically or mentally incapable of self-care. This child must meet all of the following to be a “qualifying child” for this purpose:
 - Has one of the following relationships to you
 - Your child or a descendant of your child
 - Your brother, sister, stepbrother, stepsister, or descendant of any such relative
 - Lives with you for more than 50% of the year
 - Does not provide over 50% of the child’s own financial support for the year.
 - Your opposite-sex spouse who is physically or mentally incapable of caring for himself or herself and who has the same principal residence as you for more than half of the year.
 - other tax “dependent” who is physically or mentally incapable of caring for himself or herself and who:
 - Is a relative of yours – specifically, your child or a descendant of your child; your father, mother or an ancestor of either; your stepfather or stepmother, father-in-law or mother in law, or your father’s or mother’s brother or sister; your brother, sister, stepbrother, stepsister, or your brother’s or sister’s son or daughter; or your son-in-law, daughter-in-law, brother-in-law, or sister-in-law - and has the same principal residence as you for more than 50% of the year, or is

- an unrelated individual who has the same principal residence as you for the entire year and who is a member of your household;
 - Receives more than 50% of his or her annual financial support from you; and
 - Is not a qualifying child of you or of any other taxpayer for the year.
 - In addition, a child to whom Code Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the “custodial parent” (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.
- No reimbursement can be made: (i) in an amount greater than the balance in your DCFSA Account at the time of reimbursement; or (ii) to the extent that the reimbursement would cause your total reimbursements for the Plan Year to exceed the IRS statutory limit. Your statutory limit is the smallest of the following amounts:
 - your earned income for the calendar year (after your salary reductions under the Plan);
 - the earned income of your spouse for the calendar year (your spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals), for each month in which your spouse is
 - (a) physically or mentally incapable of self-care; or
 - (b) a full-time student); or
 - either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status, as described in Q-34.
- The expenses must be incurred for services received in the Plan Year to which your contributions have been made.
- The expenses are incurred to enable you (and your spouse, if you are married) to work or be looking for work. There is an exception: if your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.
- The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside your household, they must be incurred for the care of
 - a person under age 13 who is your Dependent under federal tax law; or
 - your spouse or other person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- Expenses related to care provided by certain related individuals does not qualify:
 - your spouse or a parent of your under age 13 qualifying child;
 - your child who is under age 19 the entire year in which the expense is incurred;
 - an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent; or
- a person for whom you are entitled to a personal exemption under Code § 151(c) (claimed as a dependent on your income taxes).

Exclusions:

The items or services listed below are currently ineligible for reimbursement from the DCRA. Please note that any expense incurred prior to your participation start date or after your plan termination date is ineligible for reimbursement. Also, any expense that you claim on your federal income tax return toward the Dependent and Child Care Tax Credit is ineligible for reimbursement.

- Any expenses incurred prior to your effective date of coverage
- Overnight camp
- Clothing or equipment required for camp
- Educational fees
- Field trip fees
- Weekend or evening babysitting, unless to enable you to work

For more information about what items are—and are not—deductible Dependent Care Expenses, consult [IRS Publication 503](#) (Child and Dependent Care Expenses), or consult a professional tax advisor.

Q-38. What must I do to be reimbursed from my DCFSA?

At the time you elect to participate in the DCFSA you will receive a Convenience Card that is linked directly to your DCFSA. If you don't choose the Convenience Card option, you will be required to file a claim for each eligible Dependent Care Expense. If you choose to file a claim, you can be reimbursed either by having a check mailed to your home or a direct deposit reimbursement to your personal checking or savings account.

You can use the Convenience Card for eligible expenses at approved providers that accept signature based Debit Cards. You should always obtain a detailed receipt for your transactions, as the Claims Administrator will ask you to provide a detailed receipt or bill showing your financial responsibility for the services provided.

For a charge to a debit card that is treated by the FSA Administrator as conditional, pending substantiation, you must provide additional independent third-party information describing the goods or services, the date of the service or sale, and the amount of the transaction.

When you incur an expense that is eligible for payment, and you do not have or choose not to use your Account Convenience Card, you may submit a claim to the Administrator on a *Reimbursement Request Form*. These forms are available online at www.discoverybenefits.com or by calling the Claims Administrator at **866-451-3399**. You may also be required to provide documentation showing you have paid or are liable to pay for the eligible expense. You may mail your Reimbursement Request to the Claims Administrator at the address on the form, or to expedite the payment of your claims, fax the Reimbursement Request Form and all the necessary receipts to 866-451-3245. Supporting documentation must accompany all FSA reimbursement requests. IRS Guidelines require the submission of third-party documentation, which includes:

- Date of service
- For whom service was provided
- Name of person/group providing services (For dependent day care expenses, it must include the provider's Federal Tax ID number or Social Security Number.)
- Description of service
- Total cost of service

You will have 90 days from the end of the Plan Year in which to submit a claim for reimbursement from your DCFSA for expenses incurred during the year in which your contributions were made.

You will be notified in writing if any claim for benefits is denied. (See Q-15)

Q-39. What does it mean to incur a Dependent Care Expense?

Dependent Care Expenses must be incurred during the Plan Year, and on or after the effective date of your election to contribute to a DCFSA. *A Dependent Care Expense is incurred when the services are provided*, not when they are paid for. For example, if you pay for your child's daycare on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month. You may not be reimbursed for any expenses incurred after the close of the Plan Year in which your participation ends.

Q-40. What if my Dependent Care Expenses are less than my Plan Year election?

As described above, this is controlled by IRS rules. If your expenses are less than the amount you elect to contribute at the beginning of year, you will have to forfeit any used amounts as described in Q-16. This is often referred to as the "Use or Lose" clause. This is why you should never over estimate what you expect to spend in any year. It is better to under estimate than over estimate.

Q-41. Will I be taxed on the DCFSA Reimbursements I receive?

You will not be taxed on your DCFSA reimbursements when you receive them from the Plan. However, Banner Health cannot guarantee that your DCFSA participation will not be questioned by the IRS during an audit of your taxes. Ultimately, you are responsible for determining whether each payment you receive from the Plan is excludable for tax purposes.

Q-42. Can I still claim the Dependent Care Credit on my federal income tax?

You may not claim any other tax credit for the amounts reimbursed to you under this Plan. However, if you spend more than you elect to be reimbursed under your DCFSA, the balance of your Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Code Section 21 (Dependent Care Credit).

That is, if you elect \$3,000 of coverage under the DCFSA and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, you could take the excess \$2,000 when calculating the Dependent Care Credit. Again, it is best to consult a professional tax advisor to clarify how your expenses can be claimed.

Q-43. What is the Dependent Care Credit?

The Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability. You cannot include the same expenses that you are reimbursed under your DCFSA in calculating your expenses for the Dependent Care Credit on your incomes taxes. For more information on this credit, you may want to contact a tax advisor.

Q-44. Which way is better, to take a Tax Credit or use the DCFSA?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by claiming the Dependent Care Credit. On the other hand, the more income taxes you are required to pay, it is generally better to participate in the DCFSA. Banner Health does not suggest one form over the other. You need to determine which method is better for you. You can refer to IRS Form 2441 (Child and Dependent Care Expenses) to help you. You also may want to consult a tax advisor.

General Provisions

Filing a Claim

The Claims Administrator will provide reimbursement forms and identification cards. You must complete and sign the “Employee Statement” of the reimbursement form. A separate reimbursement form must be filed for each covered person’s claim. Itemized, original bills should be attached to the reimbursement form; unless all necessary information is included in the Physician’s billing form.

Note—All claims for services already received must be filed with the Claims Administrator no later than one hundred eighty (180) days following the date the service or was completed. Claims submitted after that time will not be paid.

Note—All claims for services to be completed in the future must be filed with the Claims Administrator not later than seven (7) days before the service is to be performed.

Note—All claims for urgent medical care or treatment, which are claims for treatment that because of the timelines for appeal under this plan could jeopardize the claimant’s life or disability, or cause the claimant unmanageable pain, must be submitted as soon as possible after the attending physician makes the determination of urgent care.

If A Claim Is Denied

- If your claim for urgent medical care or treatment is denied, the Claims Administrator will notify you of the denial within seventy-two (72) hours of receipt of the claim. In that case, the notification will be oral and a written confirmation will be furnished within the subsequent three (3) days.
- If your claim for services already received is denied, the Claims Administrator will send you a written explanation of the reasons for denial within thirty (30) days of the receipt of your claim.
- If your claim for services you expect to receive is denied, the Claims Administrator will send you a written explanation of the reasons for denial within fifteen (15) days of receipt of your claim.

The explanation, in each case, will include the reason or reasons for the denial, the Plan provisions on which the denial is based and any additional material or information necessary for you to present your appeal.

Plan Sponsor Appeal

If the Claims Administrator denies your claim for a covered service, you may send a written request for a Plan Sponsor Appeal (Appeal) to the Banner Appeals and Grievance Committee (Committee) within one hundred eighty (180) days of the notification that the original claim was denied.

If you elect this option, you or your physician or treating provider must submit a written appeal to the Committee, along with any material justification or documentation to support your request for the payment of the denied claim. You have the right to access certain information and documents from the Claims Administrator used in making the initial determination. The Claims Administrator will provide you with an explanation of your rights when you receive notice of your claim denial.

Your Appeal will be decided by the Committee. This Committee does not include the employees working with the Claims Administrator who decided your original claim or who are organizationally subordinate to those persons. The Committee will consult with a physician or physicians who are not connected with your original claim.

Timelines Applicable to the Formal Appeal Process

Within five (5) business days after receiving your written Appeal, the Claims Administrator will send you a notice acknowledging your request. The notice will include a description of the Plan Sponsor Appeal process.

The Committee will decide your Appeal and deliver a notice of its decision to you.

- If your claim was for urgent care, the Committee will notify you of its decision within seventy two (72) hours of its receipt of your Appeal. The Committee will furnish a written determination within an additional three (3) days of the initial notification of its determination.
- If your claim was for a service that had not been received, the Committee will notify you of its decision within fifteen (15) days of its receipt of your Appeal.
- If your claim is for services that have already been received, the Committee will notify you of its decision within thirty (30) days of its receipt of your Appeal. The timelines can be expanded if there are reasons beyond the control of the Committee and you are notified before the initial time for notification has expired.

The notice will include the written decision, a description of the criteria used, the clinical reasons for that decision, and any references to supporting documentation. The Committee will also send a copy of the notice to your physician or treating provider.

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out about what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

COBRA: Continuation of Coverage Option

For purposes of this SPD, “group health coverage” refers to the Health Care Flexible Spending Account – HCFSA as referenced throughout this document.

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage is a temporary extension of group health coverage under the Plan. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage under the Plan.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive COBRA coverage.

COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

For additional information about your COBRA rights and obligations under the Plan, you should contact the COBRA administrator. Contact information is provided below.

What is COBRA Coverage

COBRA coverage is a continuation of group health coverage under the Plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who Is Entitled to Elect COBRA?”

After a qualifying event occurs and any required notice of that event is properly provided to the COBRA administrator, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the components of the Plan is available in other portions of this SPD.

Who is entitled to elect COBRA Coverage?

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse's or domestic partner's hours of employment are reduced;
- Your spouse's or domestic partner employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes enrolled in CMS (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or domestic partner .

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in CMS (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

COBRA after a Leave under the Family and Medical Leave Act (FMLA)

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month

maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See section below entitled “Length of COBRA Coverage.”)

Employees Eligible for Federal Trade Adjustment Assistance

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual’s group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, promptly contact the COBRA administrator or you will lose the right to elect COBRA during a special second election period.

When is COBRA coverage available?

The Plan will offer COBRA continuation to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in CMS (Part A, Part B, or both), the employer will notify the COBRA Administrator of the qualifying event.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. If the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the COBRA Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify your COBRA Administrator**. The Plan requires you to notify your COBRA administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the form entitled “Employee/Spouse/Dependent Notice of Qualifying Event Form and Procedures” and you must follow the procedures specified on the form. If these procedures are not followed, or if the notice is not provided in writing to the COBRA administrator during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA**. You may obtain a copy of the Employee/Spouse/Dependent Notice of Qualifying Event Form and Procedures from the COBRA Administrator.

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan’s COBRA election notice and submit to the COBRA administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the COBRA administrator. Under federal law, you have 60 days from the date you receive the COBRA election

notice, provided to you at the time of your qualifying event, to decide whether you want to elect COBRA under the Plan.

The Election Form must be completed, in writing, and mailed or hand delivered to the COBRA Administrator. Oral Communication regarding COBRA coverage is not acceptable as COBRA elections and will not preserve COBRA rights.

Deadline for COBRA election

If mailed, your election must be postmarked and if hand-delivered, your election must be received by the COBRA Administrator no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

If you reject COBRA before the due date, you may change your mind as long as you furnish a complete Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. Any qualified beneficiary for which COBRA is not elected within the 60-day election period (specified in the Plan's COBRA election notice) **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You can lose the right to avoid pre-existing condition exclusions applied to you by other group plans if you have more than a 63 day gap in health coverage. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not continue COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. COBRA coverage can end before the end of the maximum coverage period for several reasons which are described in the section below entitled "Termination of COBRA Coverage before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's loses eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of employee's hours of employment, and the employee became entitled to CMS benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last for up to 36 months after the date of CMS entitlement. For example, if a covered employee becomes entitled to CMS eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of CMS entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled

to CMS within 18 months BEFORE the termination or reduction of hours. Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must provide notice to the COBRA Administrator, of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to do so will eliminate the right to extend the period of COBRA coverage.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the COBRA administrator, in writing, of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination
- The date of the covered employee's termination of employment or reduction of hours
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

You must provide a copy of the Social Security Administration's determination letter to the COBRA administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours. Failure to do so will result in a loss of entitlement for the disability extension of COBRA coverage.

Second Qualifying Event Extension of COBRA Coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the COBRA administrator, in writing, of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the form entitled “(Employee/Spouse or Dependent Notice of a Qualifying Event (Form & Notice Procedures),” and you must follow the procedures specified on the form. Failure to follow the procedures or failure to provide the notice in writing to the COBRA administrator during the 60-day notice period will result in a loss of entitlement for the second qualifying event extension.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan have been exhausted or satisfied)
- A qualified beneficiary becomes entitled to CMS benefits (under Part A, Part B or both) after electing COBRA
- The employer ceases to provide any group health plan for its employees
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled

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

You must notify the COBRA administrator, in writing, within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to CMS or becomes covered under other group health plan coverage.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan for a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage. You will be notified of COBRA premium changes by the COBRA Administrator.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health coverage, including COBRA coverage. If you have questions about these new tax provisions. You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

Payment for COBRA Coverage

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the COBRA Administrator. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. This is the date your Election Form is postmarked, if mailed or the date your Election Form is received by the individual at the address specified above if hand-delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure the amount of your first payment is correct. You may contact the COBRA administrator to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Additional Questions

Questions concerning your Plan or your COBRA rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Address Changes

In order to protect your family COBRA rights, you should keep the COBRA administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the COBRA administrator.

COBRA Administrator Contact Information

Discovery Benefits
203 10th Street North
PO Box 869
Fargo, ND 58107
866-451-3399 or 701-451-3399

Conversion Privilege

There is no conversion privilege after COBRA coverage ends.

Waiver

If the Plan Administrator fails to exercise any of its rights under the Plan, the failure to exercise any right, or the failure to require you to perform any obligations described in the Plan, will not be deemed a waiver of the right. The failure of the Plan Administrator to exercise its right will not prevent the Plan Administrator from exercising the right or requiring you to perform at any later time, and will not result in a waiver of its rights with respect to a subsequent event.

Your Rights under ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants are entitled to the following rights:

- 1) Examine, without charge, at the Plan Administrator's office, all documents, including insurance contracts and copies of all documents filed with the United States Department of Labor, such as detailed annual reports and the Summary Plan Description.
- 2) Obtain copies of all plan documents and other plan information on written request to the Plan Administrator. You may be charged for the cost of duplicating copies.
- 3) In addition to creating rights for plan participants, ERISA imposes certain duties on the people responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in the best interest of you and other plan participants and beneficiaries.
- 4) The Plan Administrator and designated fiduciaries have the discretion to determine eligibility for participation, benefits, and coverage; remedy possible plan ambiguities; and otherwise interpret the Plan in accordance with clearly defined and ascertainable criteria specifically set forth in the Plan. This discretion includes, but is not limited to, conditioning coverage or benefits on the qualified medical opinion of a physician and limiting certain benefits to the reasonable charge for the claim.

Under certain circumstances, outside assistance may be necessary to resolve disputes between you and Plan Officials. For example:

- 1) If you request materials from the company's 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.
- 2) If your claim for benefits is denied or ignored in whole or in part after a final review, you may file suit in a state or federal court.
- 3) If the fiduciaries misuse the Plan's money, or if you are discriminated against for pursuing a benefit or exercising your ERISA rights, you may seek help from the United States Department of Labor or file suit in federal court.
- 4) If you file a suit against the Plan, the court will decide who should pay court costs and legal fees. If you win your suit, the court may order the person you have sued to pay the court costs and legal fees. If you lose your suit, the court may order you to pay the costs and a fee if, for example, the court decides your suit was frivolous.

If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory

or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 2021

Summary Plan Description

The name of the Plan:

Banner Pre-Tax Plans

Plan Identification Number:

500

(Classification code used for filing with the Department of Labor and the Internal Revenue Agency.)

Type of Plan:

Group health plan and cafeteria plan under Code Section 125

Plan Year:

12 month period beginning January 1 and ending December 31

Plan Administrator/Plan Sponsor:

Banner Health

BPA Operations Compliance

525 W Brown Road

Mesa, AZ 85201

800-684-2464

480-684-7070 (in the Phoenix Metro area)

(Legal process can be served upon the Plan Sponsor at the above address.)

Claims Administrator and COBRA Administrator

Banner Health has contracted with and delegated to Discovery Benefits the discretionary authority to serve as Claims Administrator and COBRA Administrator.

Discovery Benefits

3216 13th Ave South

PO Box 869

Fargo, ND 58107

866-451-3399 or 701-451-3399