



Hellenic College, Inc.

Flexible Benefits Plan Employee Handbook

January 1, 2007 – December 31, 2007

Neil Kutzen & Universal Benefit Plans
in conjunction with and administered by:



Leggette Actuaries Inc.

**4131 N Central Expressway, Suite 1100
Dallas, TX 75204**

Tel (800) 388-4015 Fax (214) 443-0606

www.Leggette.com

SECTION 125 FLEXIBLE BENEFITS PLAN

Dear Plan Participant:

Congratulations on your election to participate in the Section 125 Flexible Benefits Plan (Cafeteria Plan).

The payroll reimbursement amounts requested by you for your Medical Reimbursement and/or Dependent Daycare Expenses will be in force with your plan year beginning *January 1, 2007*. You may access your flexible spending account 24 hours a day, 7 days a week at www.Leggette.com. You may verify your elections, check your available balance, see your claims history, print a statement, report a lost or stolen card, read more about your plan, or get answers to your questions regarding claims or filing claims.

Your handbook and the information contained herein include the following:

- (1) Explanation of a Flexible Benefits Plan and website information
- (2) Important General Information concerning your account
 - a) Elections
 - b) Claims
 - c) MBI Benefits Card/Receipts
 - d) Ineligible Expense Recovery
 - e) Qualifying Dependent Definition
 - f) Termination
- (3) Medical Reimbursement Summary- Eligible and ineligible expenses
- (4) Dependent Care Summary - Eligible and ineligible expenses
- (5) Orthodontia Reimbursement Guidelines
- (6) Claim Forms
- (7) User's Guide for creating and navigating through your online account

If you have any questions, please call our Benefits Services Department at (800) 388-4015, contact your Human Resources/Personnel Department or, for faster service, directly access your account on the Leggette web site.

LEGGETTE ACTUARIES, INC.
4131 N Central Expressway, Suite 1100
Dallas, Texas 75204
(214) 528-8850 Local
(800) 388-4015 Toll
(214) 443-0606 Fax
Flex@Leggette.com

EXPLANATION OF FLEXIBLE BENEFITS PLAN

Flexible Benefit Plans are often referred to as Section 125 Plans, Cafeteria Plans or Flexible Spending Arrangement (FSA) Plans. These plans allow you to pick and choose from a variety of insurance benefits that best meet your individual needs. Many of these benefits can be placed under the Cafeteria Plan, which means they will be taken out of your paycheck pre-tax. When you use pre-tax dollars to pay for these expenses, you will realize an increase in spending power and substantial tax savings. Employer sponsored payroll deducted insurance premiums including medical and dental insurance premiums can qualify for your cafeteria plan.

You may sign-up for medical spending accounts and dependent daycare accounts. Each plan year you can designate an amount of money to be set aside in one or both of these accounts to be taken out pre-tax. This handbook is only a summary of these accounts. If you have further questions, contact your human resources director, Leggette Actuaries or your tax advisor for further information.

WEB SITE

Visit www.Leggette.com. We have a comprehensive web site explaining all plans and how they work. You will also find a comprehensive list of all *eligible* expenses as well as examples of *ineligible* expenses. A tax calculator is available to help you estimate your tax savings and to help you figure your yearly elections for all your flexible benefits needs. All participants will be able to check their account balances 24 hours a day at www.mbicard.com. The first time you sign onto the web site to view your account balance, you will need to enter your MBI Benefits Card number and your social security number as your account number (with NO dashes).

GENERAL INFORMATION

Elections

- Elections must be made before each company plan year. No late enrollments will be accepted.
- Participant elections are irrevocable unless you have a change in family status. Examples include marriage, divorce or legal separation, birth or adoption of a child, or death of a child or spouse. Your election change must be consistent with your family status change (i.e., you may increase your election when adding dependents and decrease your election if losing a dependent). You must show proof of your status change (i.e. marriage certificate, divorce decree, etc). You can find a complete list of status changes at www.Leggette.com.
- If you are entering the plan mid-year as a new employee, all expenses eligible for reimbursement must be incurred during the time period you were eligible under the plan. Eligible expenses are not retroactive back to the beginning of the plan year.
- Flexible Spending Arrangements are a benefit provided by your employer that allows you to set aside a certain amount of your paycheck into an account before paying taxes. During the year you can be directly reimbursed from your account for medical and dependent daycare expenses.

Claims

- You cannot commingle medical reimbursement and dependent daycare funds. You must designate an amount for each account.
- Medical reimbursements will be issued up to the maximum benefit amount elected for the current plan year.
- Dependent care reimbursement checks will be issued up to the amount currently available in your account not to exceed total contributions.
- All claims must be accompanied with a claim form indicating the amount you are requesting. Claim forms are included in the back of this handbook.
- All claim forms **MUST** be signed and dated by the participant.
- Claims are generally processed within 24-48 hours.
- All reimbursements will be automatically deposited if enrolled for ACH services (ACH deposits will appear in 3 business days from date of claim processing date).

GENERAL INFORMATION

(Continued)

Temporary Carry Over Rule

- The Temporary Carry-Over Rule, IRS Notice 2005-42, permits an additional period of 2½ months immediately following the end of the plan year, in which participants may incur expenses to exhaust their benefits for that plan year. This effectively gives participants until March 15th to have services rendered for the plan year ending December 31st. During this 2½ month period, services may be rendered in the new plan year but reimbursed from the old plan year. Essentially, the IRS has delayed (but has not eliminated) the enforcement of the “use-it-or-lose-it” rule. Any benefits unused prior to the end of the TCO period remain subject to the use-it-or-lose-it rule.
- All expenses incurred during the new plan year must be filed via manual claim if seeking reimbursement from the remaining prior plan year funds. The debit card will only be linked to the current plan year.
- The run-out period (grace period) will be 45 days from the end of the temporary carry over period. Therefore, the deadline to file claims for the plan year is April 30st.
- An employee who is enrolled in the current plan year, but does not elect to enroll in the subsequent plan year may still be allowed the TCO period as well as any run-out period (grace period).

MBI Benefits Card / Receipts

- The MBI Benefits Card is issued under the MasterCard name and should be used as a credit card when swiped (there is NO PIN number). The benefit of using the MBI Benefits Card is that you do not have to pay any out of pocket expenses.
- You simply pay for your medical expenses using the MBI Benefits Card, which is linked to your flexible spending account, and then submit the proper receipts to Leggette Actuaries for claim substantiation.
- The card will only work at approved merchant locations. If your card does not work at an approved merchant, please give us a call at the number printed on the card.
- The card will be denied if the transaction is for more than what’s available in the participant’s flex account.
- All receipts will be required to be submitted unless the transaction amount matches the co-pay parameters set forth in our system to coincide with your health plan.
- Receipt notification letters will be mailed or emailed to participants notifying them of the need to submit the required documentation. ***If valid documentation has not been provided within 45 days of the date of transaction, the MBI Benefits Card will automatically be deactivated.*** Once sufficient documentation has been received, the card will be reactivated.
- If we have your email address on file, an approval letter will be emailed to notify you of transactions that have been approved.

GENERAL INFORMATION

(Continued)

MBI Benefits Card / Receipts (continued)

- Expenses must be *incurred* during the plan year regardless of when payment is made.
- Prescriptions receipts submitted for substantiation **MUST** include the name of the drug and not just the Rx number.
- All transactions that remain pending due to insufficient documentation will be deemed ineligible under IRS regulations. Therefore, all amounts will be owed back to the plan.

Acceptable Documentation:

- Explanation of Benefits (EOB) from insurance company
- Itemized statement reflecting date of services, type of services performed and amount due
- Pharmacy statement including name of drugs

Unacceptable Documentation:

- Credit card receipts
- Cash register receipts (except for over-the-counter expenses)
- Balance Forward Statements
- Canceled check copies

Ineligible Expense Recovery

- Ineligible expense recovery begins as soon as the expense is identified.
- Your dedicated account manager will use the MBI system to generate a notice via e-mail or first class mail stating the date of service, amount of the charge, vendor name and reason the expense is ineligible. Within 48 hours a second written notice will be sent out via mail listing all of the above information and giving instructions regarding the amount due back to the plan and who to direct the repayment to.
- If the participant fails to respond within 10 days, the MBI system automatically suspends use of the debit card.
- If the inability to use the card leads to the submission of a manual claim, the amount due to the plan is deducted from the value of the claim as an offset. If the full amount due is satisfied, the remainder of the claim is paid and the card is reactivated. If the full amount is not satisfied, the amount due is reduced but the card remains inactive and the participant receives a letter detailing how the claim has been applied to the account.
- If the amount remains unsettled by the end of the plan, and the employee remains with the company, the employer may have the option to generate a payroll deduction to satisfy the expense or it may be considered taxable wages at the end of the year via W2 or Form 1099.

GENERAL INFORMATION

(Continued)

Qualifying Dependent Definition

- The Working Families Tax Relief Act of 2004 created a new standardized definition of a dependent. The new definition is used to provide benefits under health plans, FSAs, HRAs, and dependent care plans. An individual is considered a dependent if they fall under ONE of the following categories: 1) **Qualified Child**, or 2) **Qualified Relative**.

To be recognized as a **QUALIFYING CHILD**, a person must meet all four tests:

- 1) **Relationship.** The taxpayer's child or step-child (whether by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of these.
- 2) **Residence.** The child has the same principal residence as the taxpayer for more than half of the tax year. Exceptions apply, in certain cases, for children of divorced or separated parents, and other special instances.
- 3) **Age.** Must be under the age of 19 at the end of the tax year, or under the age of 24 if a full-time student for at least five months of the year, or be permanently and totally disabled at any time during the tax year.
- 4) **Support.** Child did not provide more than one-half of his/her own support for the tax year.

Additional requirements:

- Be a U.S. citizen or national, or a resident of the U.S., Canada, or Mexico. There is an exception for certain adopted children.
- Marital status – If child is married, he/she did not file a joint return for that year, unless the return is filed only as a claim for refund and no tax liability would exist for either spouse if they had filed separate returns.

To be recognized as a **QUALIFYING RELATIVE**, a person must meet all four tests:

- 1) **Relationship.** An individual who bears a relationship to the taxpayer as described under Code Section 152(d)(2) [A parent, or ancestor, a step-parent, niece or nephew, half-sibling or a person related by marriage of the taxpayer], including someone who has the same principal abode as the taxpayer for the taxable year and is a member of the taxpayer's household.
- 2) **Gross Income.** Qualifying relative has gross income that is less than \$4,000 for the 2005 tax year. (Gross income limit test does not apply to health plans so you may omit this definition when looking at a health plan, health FSA, or HRA.)
- 3) **Support.** For whom the taxpayer provides over one-half of the individual's support for that calendar year, and
- 4) **Qualifying Child.** Is not an otherwise "qualifying child" of the taxpayer or of any other taxpayer for any portion of the year.

GENERAL INFORMATION

(Continued)

Employment Termination Options

- During an unpaid leave of absence, contributions to your medical reimbursement account must be made on an after-tax basis, just like your insurance premiums. When the employee returns to work the pre-tax contributions will resume.
- When an employee terminates employment, they may have the right to elect to continue their medical reimbursement account on an after-tax basis through COBRA. If your employer offers this continuation option and you do not elect to continue the payments on an after-tax basis, your coverage will stop when payments stop. Only expenses incurred during the employment period will be reimbursed. If you elect to continue coverage through COBRA, the coverage in the medical reimbursement account will continue until the premium ceases and expenses incurred during the period of coverage will be reimbursed.
- A terminated employee (not electing to continue coverage through COBRA) has **30 days** to file any outstanding claims for the current plan year during the time frame in which he/she were an active participant.
- An employee taking leave under the Family Medical Leave Act (FMLA) may revoke an existing election under group health plan coverage and make another election for the remaining period of coverage. An employee has three options: (a) pre-pay the contribution obligation on a pre-tax basis, (b) make monthly post-tax contributions or (c) catch up on the pre-tax contributions upon returning from leave.

All employees can view their accounts online 24 hours a day at www.Leggette.com

MEDICAL REIMBURSEMENT SUMMARY

- Your medical reimbursement account is used to reimburse medical treatment expenses incurred for you, your spouse and/or eligible dependents. You and your dependents do *not* need to be enrolled in your employer's group health/dental insurance plan to be eligible for reimbursement under your medical reimbursement account.
- Eligible medical expenses include co-payments, deductibles and coinsurance amounts under your group medical and/or dental plan. These must be charges in excess of benefits reimbursed under your group insurance plan.
- *The annual election maximum for the Medical Reimbursement Account is \$6,000.*

Common Eligible Expenses*

| | |
|--|---|
| Acupuncture | Hospital Bills |
| Alcohol and drug rehabilitation | Insulin |
| Ambulance | Laboratory fees |
| Artificial limbs/ teeth | Obstetrical expenses |
| Chiropractors | Oral surgery |
| Christian Science Practitioner's fees | Orthodontic expenses ** |
| Contact Lenses and solutions | Orthopedic devices |
| Co-payments | Over-the-counter items (refer to list of eligible items) |
| Confinement Costs (physical/mental illness) | Oxygen |
| Crutches | Physician fees |
| Deductibles | Prescribed medicines |
| Dental fees | Psychiatric care |
| Dentures | Psychologist's fees |
| Diagnostic fees | Routine physicals and other non-diagnostic services or treatments |
| Drug & Medical supplies (i.e. syringes, needles, etc.) | Smoking cessation programs |
| Eyeglasses prescribed by your doctor | Surgical fees |
| Eye Examination fees | Wheelchair |
| Eye surgery (including Lasik) | X-rays |
| Hearing devices and batteries | |

*This list contains the most commonly used expenses for medical reimbursement. If you have a question regarding other medical expenses contact your employer or the Benefit Services Dept at (800) 388-4015. There is an extensive list of covered expenses at www.Leggette.com

**Claims will not be accepted for the entire contract amount. Claims will be accepted for monthly payments and initial down payment. Refer to the Orthodontia Reimbursements Page for specific guidelines.

INELIGIBLE EXPENSES

- Elective cosmetic surgery and procedures
- Dental bleaching
- Marriage, family and debt counseling
- General health procedures/items (vitamins, calcium and other supplements, toothpaste, shampoo)

MEDICAL REIMBURSEMENT SUMMARY

(Continued)

Over-the-Counter Items Reimbursable Under a Flexible Spending Account

Item(s) must be purchased for a medical necessity. Medical necessity is defined as a diagnosis, cure, mitigation treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. *Items purchased for general health are not eligible for reimbursement. Stockpiling is also not allowed – 90-day supply maximum.*

| Eligible Items | Ineligible Items |
|--|--|
| <p>Allergy Medicines Antihistamines Decongestants Nasal Sprays Sinus Medications</p> <p>Pain Relievers Acetaminophen (Tylenol) Anti-inflammatory drugs Disinfecting Creams, Ointments Ibuprofen (Motrin) Fever Reducers Naproxen Sodium (Aleve)</p> <p>Cold Medicines Cough Drops Cough Syrups Decongestants Flu and Cold Medications Sore Throat Sprays Vapor Rubs</p> <p>Digestive Tract Relief Antacids Anti-diarrhea Medications Anti-nausea Medications Heartburn Medications</p> <p>Miscellaneous Contact Solution Cold Sore Remedies Eye Drops Lice Treatment Nicotine Patch / Gum Wart Removers Yeast Infection Treatments</p> | <p>Herbal Remedies Chondroitin Sulfate Echinacea Ginkgo Biloba Ginseng Glucosamine St. John's Wart</p> <p>Supplements Vitamins and Minerals * Weight Loss * Appetite Suppressants Low Calorie Foods</p> <p>Cosmetic Items Cosmetic Face Creams Shampoo Soaps and Cleansers Sundry Items Toothpaste</p> <p>* Dual Purpose Items - May be eligible for reimbursement if submitted with doctor's letter of medical necessity indicating specific medical diagnosis.</p> |

DEPENDENT CARE REIMBURSEMENT SUMMARY

Dependent Care benefits pay for your dependent daycare expenses with before tax dollars. You may choose an amount to be taken out of your check monthly and placed in an account in your name. When the dependent daycare cost is incurred, you will need to submit a claim form along with a receipt showing the amount paid for service (or have the provider's signature on the claim form). Leggette Actuaries will in turn reimburse you for these expenses. Reimbursements cannot exceed the amount in your account. If your claim is for more than what's available in your account, the remainder of the claim will be put on "hold" until the next payroll deposit is posted. You may see these claims as "denied" in your account history – be assured that these are generally only "denied" until the next payroll deposited is posted. A check will then automatically generate on the next posted pay date for the amount that was put on "hold".

Eligible Expenses

- Dependent care expenses incurred for services outside your home provided they are: 1) incurred for the care of a qualifying person who is **under age 13** when the care was provided, or 2) incurred for the custodial care of your spouse or dependent who is physically or mentally unable to care for himself or herself. Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.
- Nanny expenses, for services provided inside your home are eligible to the extent they are attributable to dependent care expenses and expenses of incidental household services.
- Employees (and your spouse if you are married) must have earned income during the year and you must pay for dependent care expenses so you can work or can look for work.
- Payments must be made for a child and dependent care to someone you (or your spouse) cannot claim as a dependent. If you make payments to your child, he or she cannot be your dependent and must be age 19 or older by the end of the tax year.
- Registration fees to a daycare facility are eligible as long as the fees are allocable to actual care and not described as materials or other fees.
- Nursery school expenses are eligible even if the school also furnishes lunch and education services.
- Food and incidental expenses (diapers, activities, etc) may be eligible if part of dependent care charge.

DEPENDENT CARE REIMBURSEMENT SUMMARY

(Continued)

Maximum Allowable

- The reimbursement may not exceed the smaller of the following limits:
 - 1) The total amount of dependent care benefits you received during the year,
 - 2) The total amount of qualified expenses you incurred during the year,
 - 3) Your earned income,
 - 4) Your spouse's earned income, or
 - 5) \$5,000 (\$2,500 if married filing separately).

Ineligible Expenses

- Kindergarten fees are almost always an education expense and cannot be reimbursed under the dependent care plan.
- Elementary school expenses for a child in the first grade or higher are not eligible. Food, transportation and incidental expenses (diapers, activities, etc.) are not eligible if charged separately from dependent care expenses.
- Mass transit and parking.
- Expenses paid to a housekeeper, cook, maid, etc., are not eligible, except where incidental to child or dependent adult care.

Divorced or Separated Parents

- If a child is claimed as a qualifying child by two or more taxpayers in a given year, the child will be the qualifying child of:
 - The parent;
 - If more than one taxpayer is the child's parent, the one with whom the child lived with for the longest time during the year, or, if the time was equal, the parent with the highest adjusted gross income (AGI);
 - If no taxpayer is the child's parent, the taxpayer with the highest adjusted gross income (AGI).

DEPENDENT CARE REIMBURSEMENT SUMMARY

(Continued)

Earned Income Limitation

- To claim the credit you (or your spouse, if you are married) must have earned income during the year. Earned income includes wages, salaries, tips, other employee compensation, and net earnings from self-employment. A net loss from self-employment reduces earned income. Your eligible expenses during the calendar year may not be more than:
 - 1) Your earned income for the year, if you are single at the end of the calendar year or
 - 2) The smaller of your earned income or your spouse's earned income for the year, if you are married at the end of the calendar year.

Dependent Care Tax Credit

- The amount you deposit in your account reduces the amount, dollar for dollar, that you can claim as a credit on your tax return.
- If you exclude dependent care assistance benefits from your employer, you must exclude less than the dollar limit for qualifying expenses (generally, less than \$3,000 if one qualifying person was cared for, or less than \$6,000 if two or more qualifying persons were cared for)
- For more information about this tax credit you can obtain IRS Publication 503. You should consult your tax advisor as to whether the tax credit will be more favorable.

GUIDELINES FOR SUBMITTING ORTHODONTIA

For orthodontia reimbursement, send a copy of your orthodontia agreement/contract along with your completed claim form. The orthodontic agreement/contract must include the following information:

- Beginning date of service
- Approximate length of service
- Total cost of service
- Record fee (if any)
- Initial fee/down payment amount
- Scheduled monthly payment/fee
- Total insurance coverage amount (if applicable)

The fee for orthodontic records is eligible for reimbursement on the date the x-rays, photos and casts are taken. Proper documentation is an itemized statement of services rendered from orthodontist's office.

The initial fee/down payment amount is eligible for reimbursement on the date of the first treatment provided proper documentation is submitted.

Subsequent monthly payments/fees, advanced prepayments and prepayments are eligible for reimbursement. Proper documentation is an itemized statement of services rendered, a receipt from the orthodontist showing date of payment ("orthodontic" clearly noted on receipt), or a copy of payment stub from orthodontic payment booklet.

Orthodontia expenses are eligible for reimbursement provided the participant was an active plan participant at the time services were rendered. Payments made during a prior plan year or prior to the participant's eligibility date are not eligible for reimbursement.

ABOUT US

Leggette Actuaries, Inc. has been providing record keeping, consulting and actuarial services to our clients since 1973. Leggette Actuaries, Inc. is a “service organization”. We are not involved in the sale of securities or insurance services or products.

Leggette specializes in the setup and installation, enrollment and communication, and ongoing administration of qualified pension, profit sharing, 401(k) and flexible benefit programs. As an actuarial consulting firm, Leggette also provides actuarial services on a consulting and/or administrative basis.

With hundreds of qualified plans under administrative management, Leggette has become well known for its outstanding actuarial and administrative services.

Leggette actuaries, senior administrators and programmers all strive to provide our client base with the most accurate, timely, and personalized reporting available. Our professional consulting staff focuses exclusively on the rapidly changing area of qualified, corporate retirement planning. It has been for these reasons that Leggette has enjoyed continued success.