FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION (SPD)

FOR

GOOD SAMARITAN HOSPITAL
1225 Wilshire Blvd.
Los Angeles CA 90017

Administered By

ZENITH AMERICAN SOLUTIONS
Flexible Spending Accounts Department
PO Box 91082
Seattle WA 98111-9182
(206) 281-1580

January 2009
Revised January 2012
GOOD SAMARITAN HOSPITAL
FLEXIBLE SPENDING ACCOUNTS

**General Information**

**Claims Administrator**
Zenith American Solutions
PO Box 91082
Seattle, WA  98111-9182
(206) 281-1580 or 800-426-5980
Fax:  (206) 285-4789

**Plan Year**
January 1 to December 31

**Open Enrollment**
September or October each year.

**Maximum Contributions (Annually)**
- Medical Reimbursement Account - $2,500 ($96.15 maximum per pay period)
- Dependent Care Reimbursement Account - $5,000 ($192.30 maximum per pay period)

**Minimum Contributions (Annually)**
- Medical Reimbursement Account - $5.00 per pay period
- Dependent Care Reimbursement Account - $5.00 per pay period

**Reimbursement**
Checks are issued on 15th and last day of each month. Claims must be received at least two days prior to issue date for reimbursement to be made. Allow 5-6 days from issue date to receive your check.

If you pay ahead for future dates of service, or services not yet rendered, the expenses are not eligible for reimbursement until the date of service has been incurred.
Eligibility
Employees can elect to participate at the time of employment and during each annual enrollment period by completing an enrollment form for the new January 1 Plan Year.

For Tax Purposes
Retain copies of all submissions and maintain the same record keeping procedure that you currently use for preparing your year-end tax return.
GOOD SAMARITAN HOSPITAL

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What is a Flexible Spending Accounts Plan?

A Flexible Spending Accounts Plan is a plan provided by your employer offering you the opportunity to select benefits that best fit your needs.

Your employer is able to provide these tax-free benefits to you under Section 125 of the Internal Revenue Code.

There are two types of spending accounts: medical and dependent childcare.

A Medical Spending Account allows you to set aside pre-tax dollars to pay for eligible medical expenses for which you do not receive any reimbursement.

A Dependent Care Spending Account allows you to set aside pre-tax dollars to pay for daycare expenses for children under the age of 13. It also allow for expenses for adult daycare for a disabled spouse or other disabled dependent.

Who Is Eligible To Participate?

Generally, if you are eligible to participate in your employer's group health plan, you are eligible to participate in the Flexible Spending Accounts Plan. Ask your Human Resources Department for details.

To become a participant, you must sign the Flexible Spending Accounts Enrollment Form. The form must be completed and signed prior to your effective date in the Plan.

If you will be an eligible employee on the first day of the plan year, your effective date will be the first day of the plan year. If you become an eligible employee after the commencement of the plan year, your effective date will be the first day of the month coincident or following the date you become eligible to participate. Your payroll reductions will start on the first payday on or after your effective date.

If you do not complete the Flexible Spending Accounts Enrollment Form prior to your effective date indicated above, you will not be eligible to participate in the plan until the following plan year unless you have a change in family status.

When Does Your Participation Terminate?

You will remain a participant in the Flexible Spending Accounts Plan until the earliest of the following dates:

- The date you are no longer an eligible employee
- The date you stop contributing to the Plan
- The date of your termination of employment
- The date the Plan year ends
- The date the Plan ends
What Are Your Benefits?

Beginning on your effective date in the Plan, you may choose to redirect your salary in order to pay for the following benefits tax-free:

- **Medical Reimbursement Plan** - Allows you to pay for your medical, dental and vision out-of-pocket expenses before taxes.

- **Dependent Care Reimbursement Plan** - Allows you to pay for employment-related daycare expenses before taxes.

Each new plan year, during the open enrollment period, you must complete and sign a new Flexible Spending Accounts Enrollment Form.

Once you have enrolled in the Plan and the plan year has begun, you cannot revoke, discontinue or change your election for the duration of the plan year unless you have a qualified change in status. If you have a qualified change in status, you are allowed to change your election, if the change is appropriate and consistent with your change in status.

Some examples of changes in status are as follows:

- Change in the employee’s legal marital status;
- Change in the number of Dependents;
- Change in employment status;
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
- Change in residence; or
- Commencement or termination of adoption proceedings

Contact your employer immediately if you experience a qualified change in status and would like to change your election. Your employer will have you complete a Flexible Spending Accounts Enrollment Change Form. You must complete and return the form to your employer within 30 days of your change in status. The effective date of the change will be the first day of the month following the date you signed the form, not the date of the change in status.

If you elect to reduce the contribution to your Medical Reimbursement Account due to a qualified change in status, your annual contribution amount will be recalculated and reduced based on your new election, regardless of the amount of reimbursements made to you. If you elect to increase the contribution to your Medical Reimbursement Account due to a qualified change in status, your annual contribution amount will be recalculated and increased based on your new election, regardless of the amount of reimbursements made to you.

If you elect to terminate the contribution to your Medical Reimbursement Account due to a qualified change in status, your eligibility will also terminate. Therefore, claims with dates of service occurring after your termination date from the Medical Reimbursement Account Plan will not be eligible for reimbursement. Per IRS Regulations, the date of service is the date the medical care was given, not the date you were billed or charged, or the date you paid for the service.
**90 Day Grace Period for Submission of Claims**

You will have 90 days to submit claims after the close of the plan. The dates of service must have occurred during the plan year, while you were participating in the plan.

**The Important "USE IT OR LOSE IT" Rule**

The IRS has a “Use It or Lose It” rule that states that any contributions left in the spending accounts and not reimbursed to the participants by the close of the plan year run out period are considered “forfeited funds.” Forfeited funds are returned to the employer after the close of the plan year run out period. The employer may keep the funds.

**The Medical Reimbursement Plan**

If you know you will have out-of-pocket health care expenses during the plan year, you may elect to use the Medical Reimbursement Plan to pay for them with tax-free dollars. After you determine the amount of out-of-pocket expenses you know you will incur during the plan year, your employer will divide the amount by the number of pay periods you will have during the plan year. Your employer will deduct that amount from your salary each payday, prior to calculating your federal taxes. The money will be placed in your Medical Reimbursement Plan Account. As you incur out-of-pocket expenses, you will submit a request for reimbursement by completing a Medical Reimbursement Claim form, along with supporting documentation, to Zenith American Solutions. Please see "How to Submit a Reimbursement Claim" for detailed instructions.

Health care expenses that are eligible for reimbursement, per IRS regulations, are expenses incurred by you, or your spouse or dependent, for medically necessary services as defined in Section 213 of the IRS Codes. Expenses are treated as having been incurred when the medical care was given, not the date you were billed or charged, or the date you paid for the services. In addition, the expense must not be eligible for reimbursement from any other health plan.
**Eligible Medical Expenses**

The following is a partial list of medical expenses that are eligible for reimbursement from a medical spending account. Please refer to IRS Publication 502 (available by calling 800.829.3676 or logging on to www.irs.gov/formspubs) for more information prior to making an election. The expense is allowed only if certain qualifying conditions exist. Employees are requested to call Zenith American Solutions prior to making their elections if they have any questions about whether or not an expense will be eligible for reimbursement.

In general, eligible expenses include deductibles and copayments, eligible expenses not covered by your medical, dental or vision plan, and most things that qualify as a medical deduction under the Internal Revenue Code.

- Abortions, legal
- Acupuncture
- Alcohol and Substance Abuse
- Ambulance
- Artificial limbs
- Birth control pills
- Chiropractor
- Christian Science Practitioner’s fees
- Contact lenses & solution
- Crutches
- Dental fees (non cosmetic)
- Diagnostic fees
- Eyeglasses & exams
- Hearing aids & batteries
- Hospital services
- Immunizations
- Insulin
- Laboratory fees
- Medical services
- Naturopathic physicians
- Nursing services
- Orthodontia (1)
- Osteopath
- Over-the-Counter medications (only with doctor’s prescription)
- Over-the-Counter supplies (band-aids, adult diapers, etc.)
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist
- Smoking cessation programs
- Sterilization
- Sunglasses, by prescription
- Telephone for hearing impaired
- Television for hearing impaired
- Transplants (organ)
- Transportation
- Weight loss programs (not food)
- Wheelchair
- X-Ray

(1) Orthodontia (on a monthly basis only). Please note: Charges for services not yet rendered are not allowed. Up-front reimbursement for the entire treatment is prohibited, unless treatment is complete and braces have been removed.

**Ineligible Medical Expenses**

The following partial list of expenses is NOT eligible for reimbursement from a medical spending account.

- Baby-sitting and child care
- Bleaching teeth (cosmetic)
- Cosmetic surgery
- Diaper service
- Dietary Supplements (Vitamins)
- Electrolysis (cosmetic)
- Face lifts (cosmetic)
- Food (included w/ weight loss programs)
- Funeral expenses
- Hair transplants (cosmetic)
- Health club membership dues
- Household help
- Illegal operations or treatments
- Laetrile
- Liposuction (cosmetic)
- Marijuana used medically
- Marriage or family counseling
- Maternity clothes
- Medical insurance premiums
- Medicated shampoos & soaps
- Personal use items
- Prescription drugs considered cosmetic
- Rogaine (cosmetic)
- Swimming lessons
- Toothbrushes (even if provider recommends special type to treat a condition)
- Vitamins or other Dietary Supplements
- Any expense not considered “medically necessary” as defined by the IRS.

For a complete list of Eligible and Ineligible expenses, please refer to IRS Publication 502 (available by calling 800.829.3676 or logging on to www.irs.gov/formspubs)
The Dependent Care Reimbursement Plan

If you know you will have employment-related dependent daycare expenses for an eligible dependent during the plan year, you may elect to use the Dependent Care Reimbursement Plan to pay for them with tax-free dollars. This may be done only if the expenses are incurred to allow you (and your spouse, if applicable) to work. (Student status may also qualify under the plan as "work"). The maximum amount you may contribute to the plan in a calendar year is $5,000 ($2,500 if married but filing separately), or an amount equal to your salary or your spouse's earned income (as defined by the IRS), whichever is the least.

An eligible dependent is:

- Your child who is under 13 years of age, or
- Your spouse (or other individual claimed as a dependent for federal tax purposes) who is physically or mentally incapable of self-care and who regularly spends at least eight hours a day in your home.

Dependent care can be rendered either inside or outside the home. If care outside the home is provided by a dependent care center that cares for seven or more children, it must comply with all applicable state or local laws and regulations. Also, the provider must not be your child under the age of 19 or someone who you claim as a dependent for federal income tax purposes.

After you determine the amount of dependent care expenses you will incur during the plan year, your employer will divide the amount by the number of pay periods you will have during the plan year. Your employer will deduct that amount from your salary each payday, prior to calculating your federal taxes. The money will be placed in your Dependent Care Reimbursement Plan Account. As you incur dependent care expenses, you will submit a request for reimbursement by completing a Child/Dependent Daycare Reimbursement Claim form, along with supporting documentation, to Zenith American Solutions.

Depending on your income level, you may also use the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these up to the maximum allowable, (or a combination of the two), but you may not take a tax deduction for those expenses reimbursed under this plan, or vice versa. See IRS Publication 503 or your tax advisor for more details.

Reimbursement of dependent care expenses will be made from the amount you have designated to the Dependent Care Reimbursement Account. Any reimbursement will not exceed the balance in your account when your claim is received.

Dependent Care “Use-Up” Rule

When you terminate your employment with Good Samaritan Hospital, your contributions to the Dependent Care Flex Account will cease. If you have a balance in your Dependent Care Flex Account at the time of termination, you will have until the end of the Plan Year to incur daycare expenses that are related to your new employment. Also eligible for Dependent Care Reimbursement are daycare expenses incurred while searching for new employment, or daycare expenses incurred because one or both of the parents of the child needing daycare either work or attend school full time. These daycare expenses must be submitted to Zenith American Solutions within the 90-day grace period after the Plan Year ends. The claims must be postmarked on or before the end date of that 90-day grace period.
**Can The Plan Be Changed?**

The plan is intended to comply with all applicable sections of the Internal Revenue Code. Your rights to this plan automatically change with changes in the Internal Revenue Code. Your employer also has the right to amend or terminate the plan at any time in accordance with the guidelines set forth in the plan document.

**How To Submit A Reimbursement Claim**

A reimbursement claim should be filed as soon as possible after the expense has been incurred. You must complete the appropriate claim form in full and provide supporting documentation. The reimbursement claim form is available on the Zenith American Solutions Flexible Spending Accounts web site at www.zenithfsa.com.

For Medical and Dependent Care Reimbursement Claim Submissions:

- Complete a Medical and Dependent Reimbursement Claim form in full.

- For Medical Reimbursement, attach a copy of your Explanation of Benefits from your health insurance company, or an itemized billing from the provider showing dates of service and charge. IRS regulations require you to provide this documentation in order for reimbursement to be made by Zenith American Solutions. Payment receipts, canceled checks or balance due statements, are not sufficient. In addition, an Explanation of Benefits which does not provide the dates of service is not acceptable.

- For Dependent Care Reimbursement, attach a copy of your daycare provider’s billing showing dates of service and charge.

- Please complete all sections of the claim form in order for Zenith American Solutions to process your claim. If you fail to complete the form in full and/or you do not provide an Explanation of Benefits or itemized billing showing dates of service and charge, your claim will be denied.

Mail your claims to:  
Zenith American Solutions  
201 Queen Anne Avenue North  
Seattle, WA  98109

Or fax to:   
(206) 285-4789

Please retain originals of all claims and documentation for IRS purposes. It is your responsibility to provide the claims information if you are audited by the IRS.

**If You Have Questions Regarding Your Plan**

If you need additional information about your Flexible Spending Accounts Plan, please contact the Zenith American Solutions Flexible Spending Accounts Department at the following numbers:

1-800-757-0071 opt 2.
Statement of Your ERISA Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all participants shall be entitled to:

1. Examine without charge, at your employer’s office and at other locations (worksites and union halls) all Plan Documents, including insurance contracts, any collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all Plan Documents and other Plan information upon written request to your employer.

In addition to creating rights for Plan participants, ERISA imposes obligations upon your employer who is responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries.

No one, including your employer, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefits under the Plan or exercise your rights under ERISA.

If your claim for benefits under the Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and your claim reconsidered.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require your employer to provide the material and pay you up to $100 a day until you receive the materials, unless the materials were not provided for reasons beyond the control of your employer. If you have a claim for benefits which is denied or ignored in whole or part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan monies, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who will pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact your employer. If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

COBRA Rights

To the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, codified under Code Section 4980B), the Participant, their Spouse and Dependents, whose coverage terminated under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue their coverage under this Plan on an after-tax basis for the duration prescribed by COBRA and subject to all conditions and limitations under COBRA.

If you have questions about the Plan, you should contact your employer. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.
**Proof of Eligible Expenses Required Documentation**

<table>
<thead>
<tr>
<th>Dependent Care</th>
<th>Eligible</th>
<th>Ineligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Daycare of a qualified dependent under the age of 13 or disabled dependent or spouse of any age. Daycare expenses that are incurred so you and your spouse can work, look for work, or be full time students. School tuition prior to first grade if it cannot be separated from the daycare expense. Refer to IRS Publication 503 for additional information about eligible expenses.</td>
<td>Daycare provided for children 13 years and older. School tuition for kindergarten, first grade or higher. Daycare expenses incurred while you and your spouse are not working (such as vacation) or are not full-time students. Daycare expenses paid to your dependent under the age of 19 or dependent of any age. Refer to IRS Publication 503 for additional information about ineligible expenses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Acceptable Forms of Substantiation</strong></th>
<th><strong>Manual submission:</strong> Reimbursement Request Form that includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Dates of service</td>
<td></td>
</tr>
<tr>
<td>- Amount of service</td>
<td></td>
</tr>
<tr>
<td>- Daycare provider’s name and address</td>
<td></td>
</tr>
<tr>
<td>- Daycare provider’s tax ID or Social Security number</td>
<td></td>
</tr>
<tr>
<td>- Daycare provider’s signature</td>
<td></td>
</tr>
</tbody>
</table>

| **Unacceptable Forms of Substantiation** | |
|-----------------------------------------| |
| Missing provider signature, tax ID or Social Security number. Future expenses. | |

N/A |
**Important Points to Remember**

✓ Once you elect to participate in the Flexible Spending Accounts Plan, you cannot change or terminate from the plan until the end of the plan year, unless you have a qualified “change of status.”

✓ You will have 90 days to submit claims after the close of the plan year. The dates of service must have occurred during the plan year, while you were participating in the plan.

✓ If you do not incur enough eligible medical expenses during the plan year, or fail to submit eligible expenses before the end of the 90-day period, the balance(s) in your account(s) cannot be returned to you. Per IRS Regulations, the forfeiture amount must be retained by your employer and must be used to offset the cost of your employee benefits plan.

✓ All Flexible Spending Accounts reimbursement checks will be made to you, not to the provider of services.

✓ These accounts are established as “reimbursement” accounts. It is your responsibility to pay the provider for services rendered, and then submit your claim to Zenith American Solutions for reimbursement.

✓ At the end of each plan year, you must re-enroll in the Flexible Spending Account(s). At that time, you may elect to change, increase, or decrease your contribution or terminate from the plan.

✓ Under Medical Reimbursement, if you terminate from the plan during the plan year due to a qualified change in status, or you terminate employment during the plan year and elect not to continue contributing to your account, the only dates of service that will be eligible for reimbursement are those which occurred during the time you were contributing to the account.
Orthodontia Reimbursement under the Medical Flexible Spending Account:

In the following example, the employee’s Flexible Spending Accounts Plan Year starts May 1, 2007 and ends April 30, 2008. The Employee is effective May 1, 2007.

Example: Tommy has braces installed on June 20, 2007. The total cost of the orthodontic treatment is $4,000.00. The dentist estimates the braces will be on for 24 months. The dentist charges $4,000.00 up front and employee pays the full $4,000.00. Even though the employee has paid the bill in full, the plan cannot reimburse the full amount because the treatment has not been completed. In fact, the $4,000.00 is for treatment rendered over the next 24 months. In order to determine the amount that is eligible for reimbursement in June, the dentist needs to determine how much of the $4,000.00 charge is actually for the banding. The remaining balance will then be divided by the number of months for that treatment in order to determine the eligible monthly reimbursement amount for July 2007 through April 2008.

<table>
<thead>
<tr>
<th>Total Charge:</th>
<th>$4,000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Banding Fee</td>
<td>$ 350.00</td>
</tr>
<tr>
<td>Balance Remaining:</td>
<td>$3,650.00</td>
</tr>
</tbody>
</table>

Divided by 24 months = $152.09

Reimbursement Monthly (July 2007 through April 2008) = $152.09

The Medical Flexible Spending Account will reimburse the $350.00 banding fee when first submitted, and $152.09 each month, as each month of service passes, until the end of the plan year. However, reimbursements are not automatic. The employee MUST complete a Medical Flexible Spending Account Claim Form, and attach some form of proof that Tommy is still in active orthodontic treatment. If the monthly orthodontic adjustments are on the 15th of each month, a claim form and receipt or note from the dentist stating that the patient is in active treatment can be submitted on or after the 15th of each month. **We will not reimburse the employee for services not yet rendered.**

At the end of the Plan Year (in this case April 30, 2007) in order to continue the monthly reimbursements of $152.09 the employee must re-enroll in the Medical Flexible Spending Account. As the employee submits a claim form and receipt from the dentist monthly, reimbursements will be made (unless employee terminates coverage, has a change of status or exhausts available funds from the Medical Flexible Spending Account). For each Plan Year where there is a balance remaining on the Orthodontic Service, the employee will need to re-enroll for that Plan Year.