MedCath Incorporated
Flexible Benefits Plan

Summary Plan Description
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FLEXIBLE BENEFITS PLAN

OVERVIEW

The Employer offers a Flexible Benefits Plan that can help you offset expenses by allowing you to use pre-tax dollars to pay for certain expenses.

Pre-tax dollars are dollars that are set aside from your earnings before taxes are assessed.

These pre-tax dollars are used to pay your Premium Conversion Plan contributions, and your eligible expenses for dependent care and health care. The following flexible benefits are available to you each year. You may elect to participate in any or all of these options:

PREMIUM CONVERSION PLAN OPTIONS:

Health Plan Coverage
(Medical and/or Dental)

SPENDING ACCOUNTS:

Dependent Care
Health Care

Each option under the Flexible Benefits Plan has separate rules governing benefits and plan administration, subject to the provisions of applicable Federal legislation, which is commonly referred to as Section 125. The benefits are described briefly in this overview and in more detail on the following pages.

PREMIUM CONVERSION PLAN -- If you elect medical and/or dental plan coverage your cost will automatically be deducted from your earnings on a pre-tax basis -- unless you advise your Human Resources Manager otherwise, in writing, at the time of enrollment.

SPENDING ACCOUNTS -- If you want to pay for your health care and/or dependent care expenses with pre-tax dollars the estimated expenses will be deducted and set aside from your earnings on a pre-tax basis.

The Employer will use these contributions to establish a Flexible Spending Account specifically for you.

The Flexible Spending Account (FSA) is easy to use:

- You contribute a set amount from each paycheck to your FSA.
- No taxes will be withheld on the amount you contribute to the FSA.
- You submit a request for reimbursement from your FSA after you have incurred a health expense, or paid for a dependent care expense.
- A check will be issued to you from the FSA.

Advantages of FSA

- You take home more of your earnings because you are setting aside money for your estimated expenses with pre-tax dollars. This will lower your taxable income before Federal income tax and social security tax are withheld from your earnings.
- There is no charge to you for the tax advantages offered by this plan.
- Your reimbursements from the FSA are not taxed.
- Your tax savings for dependent care may be greater with an FSA than with the Federal income tax credit.

Disadvantages of FSA

- You must use all the money set aside for your estimated expenses, or forfeit what is not used.
- You must leave your elections under the Plan unchanged for one year, unless you experience a qualifying status change.
- Your Social Security benefits may be slightly reduced because your taxable income is reduced. This process reduces the amount of contributions that you make to the Federal social security system, as well as the Employer’s contribution to social security on your behalf.
- Your tax savings for dependent care may not be greater with an FSA than with the Federal income tax credit.

ELIGIBILITY

Premium Conversion

You are automatically eligible to make pre-tax contributions under the Premium Conversion Plan if
the Employer has offered you the opportunity to elect an option under the Premium Conversion Plan.

**Spending Accounts**

You are immediately eligible to participate in the Flexible Benefits Plan Spending Accounts if you are a full-time or part-time Employee.

For you to be considered full-time or part-time you must be regularly scheduled to work at least 24 hours a week for more than 26 weeks per year. This includes seasonal and winter work employees. This does not include temporary, contract, PRN, pool, non-benefitted core employees, or regular no benefit employees.

**PREMIUM CONVERSION PLAN**

Any required contribution for the health plan coverage you elect will automatically be made on a pre-tax basis under the Employer’s Premium Conversion Plan -- unless you advise your Human Resources Manager otherwise, in writing, at the time of enrollment. The options available to you under health plan coverage include the following:

- Medical
- Dental
- Medical and Dental

This arrangement is administered in accordance with the provisions of Federal regulations for a Section 125 Plan.

Participation in a Section 125 plan requires that you continue your elections for the remainder of the Plan Year until the next enrollment period. Exceptions may be made for you or your Dependent(s), as outlined in the section entitled Participation, Status Change.

For a specific description of the Health Benefit Plans, refer to the MedCath Incorporated Group Health Benefits Plan Document.

For a specific description of the remaining Plan options contact your Human Resources representative.

Your portion of the cost for your elections under the Premium Conversion Plan is deducted from your earnings in equal amounts, or prorated for the Plan Year. This means that the deduction for each pay period is determined by dividing your cost for the Plan Year by the number of pay periods in the Plan Year.

**SPENDING ACCOUNTS**

You may take advantage of the tax savings offered by Flexible Spending Accounts simply by predicting certain expenses for the coming Plan Year, and having the money for those expenses set aside from your regular earnings before taxes are assessed. The deduction (or contribution) from your earnings is prorated, which means that the earnings reduction for each pay period is determined by dividing your contribution for the Plan Year by the number of pay periods in the Plan Year.

This arrangement is administered in accordance with the provisions of Federal regulations for a Section 125 Plan.

Participation in a Section 125 plan requires that you continue your elections for the remainder of the Plan Year until the next enrollment period. Exceptions may be made for you or your Dependent(s), as outlined in the section entitled Participation, Status Change.

If you choose to participate in the Flexible Spending Plan for dependent care expenses and/or for health care expenses your Employer will establish a separate bookkeeping account for each in order to manage your funds. This account is referred to as a Flexible Spending Account (FSA).

Based on your elections, your Employer will set aside pre-tax dollars from your regular earnings. These pre-tax dollars are referred to as contributions to your FSA(s). This action reduces your taxable earnings, but it will appear as a deduction on your earnings statement.

You will be reimbursed from the FSA after you incur eligible expenses and submit a request for reimbursement. See the Qualified Expenses and Reimbursement sections below.

Expenses that are reimbursed from your Flexible Spending Account (FSA) may not be claimed as deductions for Federal income tax purposes. You may claim an expense only once -- either through your FSA or on your Federal income tax return.

Each FSA is independent of any other. For example, the funds from your health care FSA may not be used to reimburse dependent care expenses.

Reimbursements from an FSA are made only for expenses that are incurred during the current Plan Year. You can not receive reimbursement for expenses that were incurred at any time other than during the current Plan Year.

**Estimating Expenses**

You must estimate your eligible health care and dependent care expenses for the coming Plan Year and then elect, through the enrollment process, to make salary reduction contributions in that amount. Your estimate should be calculated very carefully,
considering all expenses that you expect to encounter.

You may want to be conservative in your estimate when you are uncertain about a particular expense item. Carefully consider the following facts:

- If your actual expenses exceed the contribution you make to your FSA you may still claim any such eligible expenses as a Federal income tax deduction.
- If your actual expenses are less than the contribution you make to your FSA you will forfeit, or lose, the amount of money by which you over-estimated.

The minimum contribution you must make to an FSA is $50 per year. The contribution you determine to make after estimating your expenses may not exceed the maximum contribution allowed by the program. See the Maximum Plan Year Contribution section, below.

The use of Flexible Benefits Plan Spending Accounts can result in significant tax savings to you. This savings will help to offset your health care and dependent care costs. However, you may want to compare these tax advantages to those available under the Federal Tax Credit for dependent care to be certain which better serve you and your family.

**Maximum Plan Year Contribution**

**Health Care Contribution**

The contribution you elect to make for anticipated health care expenses for the Plan Year may not exceed the maximum contribution allowed by the program, which is $4,000.

**Dependent Care Contribution**

The contribution you elect to make for anticipated dependent care expenses for the Plan Year may not exceed the maximum contribution allowed by the program, which is an amount that is the least of the following:

- If you are single, or married filing a joint Federal income tax return – $5,000
- If you are married and file a separate Federal income tax return – $2,500, rather than $5,000, unless:
  - You are legally separated
  - Your spouse does not reside with you, and you provide the dependent’s residence for more than six months during the Plan Year
- If you are married and file a separate Federal income tax return, and your spouse also makes contributions to an FSA – the difference between your spouse’s contribution and $5,000 (which would result in a combined contribution of $5,000).
- If you are single – your earned income for the year.
- If you are married and your spouse is working – your or your spouse’s earned income, whichever is less for the Plan Year.
- If you are married and your spouse is either a full-time student or is physically or mentally incapable of self care – $200 per month for one dependent, or $400 per month if you have more than one dependent.
- If your spouse has no earned income – you may not contribute any amount to a dependent care FSA.

**Qualified Expenses**

**Health Care Expenses**

Your FSA can be used to reimburse medical and dental expenses that qualify as Federal income tax deductions.

Health care expenses that are eligible for reimbursement include your out-of-pocket health care expenses that are not covered by your health care plan. This generally includes the following:

- Deductibles
- Copays
- Coinsurance
- Expenses that exceed any Plan limits
- Expenses that exceed usual and customary charge
- Most expenses that are medically necessary or prescribed by a licensed physician.

There is a wide range of expenses that are eligible, for example: vision care, child-birth classes for an expectant mother, infertility treatment, acupuncture, medical care in a nursing home, guide dogs, and special equipment or training related to disabilities.

Not included as eligible expenses are the cost of coverage under any other health plan, including coverage under a spouse’s plan; premiums for any long term care insurance; and expenses such as, but not limited to, hair transplants, health clubs, nutritional supplements, custodial care, domestic help, and non-reconstructive cosmetic surgery.
Contact your Plan Administrator to determine the eligibility of specific expenses you may anticipate for you and/or your dependents. You may also refer to IRS Publication 502 for current information regarding what expenses you may deduct from your Federal income tax.

**Dependent Care Expenses**

Your FSA can be used to reimburse dependent care expenses that would qualify as Federal income tax deductions, provided those expenses are incurred for an individual who qualifies as your dependent for Federal tax purposes.

A qualified dependent must also be an individual who:

- Is a child under age 13, or
- Requires full-time care because of physical or mental incapacity, such as a disabled spouse or disabled parent, or
- Is the spouse of the Employee and is physically or mentally incapable of self care.

Dependent care expenses that are eligible for reimbursement include expenses you must pay for personal care of a child or other dependent, including related housekeeping or facility expenses if required for the qualifying individual, in order for you (and your spouse) to be gainfully employed.

Dependent care generally includes the situations listed below. Facilities that care for more than six individuals must be licensed and in compliance with any applicable state and local law.

- A day care center, summer day camp, preschool or after school facility.
- An adult day care facility.
- In-home day care provided in your home, or in the home of the caregiver.
- Housekeeping services provided in your home when incidental to the care of a qualified dependent, such as those provided by a maid, babysitter, housekeeper, cook or cleaning person.

Expenses that are not eligible include, but are not limited to the following: overnight camp, care provided during your (and your spouse’s) non-working hours, care given by a dependent relative or child under age 19, housekeeping not related to dependent care, health care expenses, child support, food, clothing, education, transportation, residential programs, nursing homes, or care provided outside your home for a dependent who does not regularly spend at least eight hours per day in your home, such as full-time care in a nursing home for a dependent parent.

Contact your Plan Administrator to determine the eligibility of specific expenses you may anticipate for your dependents.

**Reimbursement**

To obtain reimbursement from your FSA you must submit a completed Flexible Spending Account Reimbursement Request Form in accordance with the instructions you receive from your Human Resources Manager. This form is provided by your Employer and may be obtained from your Human Resources Manager.

Your request must include an attachment, such as an explanation of benefits, invoices or statements, that verifies your expenses. The Plan may request additional documentation as necessary. For dependent care expenses you must also include the name, address and taxpayer identification number of the caregiver.

- You will be reimbursed for eligible expenses that are incurred during the Plan Year, provided you were participating in the Plan on the date the expenses were incurred, when you submit the completed request form.
- Expenses are considered to be incurred on the date the service is rendered, not the date you make payment or submit the expense.
- No reimbursement will be made later than 90 days after the end of the Plan Year in which the expenses were incurred.
- Dependent care expense reimbursements will not exceed the current balance of your FSA.
- Except for the final reimbursement claim for a Plan Year, no claim for reimbursement may be made for an amount less than $10.

**Appeal**

If your request for reimbursement is denied, in whole or in part, you will receive written notice within 90 days of the date the reimbursement request was received. This notice will include the following:

- Reason for denial
- Specific Plan provision involved in the denial
- Explanation of how a reimbursement request is reviewed
- Appeal procedure for requesting a review of the denied reimbursement request
- Description of the information that must be submitted with an appeal.
To review administrative documents that are pertinent to the reimbursement request, you must send a written request to your Human Resources Manager, who will direct your request.

To appeal the denial of a reimbursement request, you must take the following steps:

- You must send a written notice to your Human Resources Manager within 60 days of the date your reimbursement request was denied.
- You must state in this notice the reasons why the reimbursement request should be reviewed.
- You must include any documents, data, questions or comments, and copies of all bills and claim forms, etc., that relate to your reimbursement request.

The Plan Administrator will review your appeal and notify you in writing of its final decision, including the specific reasons for the decision and the Plan provisions involved.

The Plan Administrator’s decision will be made within 60 days after receiving your appeal, unless there are special circumstances. If special circumstances require an extension of time, you will be notified of the need for this extension during the 60 days following receipt of your appeal.

If the reimbursement request is denied after appeal, you may, within 60 days of receiving the second denial, make a final appeal for review by the Employee Benefits Committee. This appeal should be made in the same manner as the first appeal, described above. Any new documentation related to the claim should be included with this request.

A final decision will be made by the Employee Benefits Committee within 60 days of the date your request is received or within 120 days if there are special circumstances requiring such an extension.

Except for duties performed by the Plan Administrator, the Employee Benefits Committee has the complete discretionary authority to adopt such rules for the administration of the plan as it considers desirable, and may construe and interpret the plan, determine eligibility, correct defects, supply omissions, and reconcile inconsistencies and decide issues of credibility to the extent it deems necessary to operate the plan. Any actions taken pursuant to this paragraph are discretionary actions of the Plan Administrator and shall be conclusive, final, and binding on all parties.

The appeal process is subject to the rules governing plan administration, except that an additional 60 days is allowed for the appeal process. This 60-day allowance will extend beyond the end of the reimbursement period, which ends 90 days after the end of the Plan Year. Therefore, any appeal process must be concluded no later than 150 days after the end of the Plan Year, regardless of any time frames described above.

**Forfeiture**

In order to provide you with the tax savings advantage of the Flexible Spending Plan, the Federal government requires that you submit all reimbursement requests for expenses that occurred during the current Plan Year no later than 90 days after the end of the Plan Year. At that time any funds remaining in the account will be forfeited. This is commonly referred to as the “use it or lose it” rule.

Balances in an FSA may not be combined with another FSA, carried over into the next year, applied to expenses that occurred in a different Plan Year, or converted to cash.

You will periodically receive statements during the Plan Year so that you will be aware of any remaining balance in your FSA. You must submit requests for reimbursement of eligible expenses that equal or exceed your entire contribution, or forfeit the remaining portion of your contribution.

**PARTICIPATION**

**Open Enrollment**

You may enroll in the Flexible Benefits Plan's optional benefits only during a scheduled open enrollment period. You may elect a completely different set of optional benefits each year, but you must complete a new election form each year, as described in this section under Existing Employee. The Employer will provide you with a written election form that will enable you to indicate the options you are choosing and the amount of pre-tax dollars that will be applied to each Flexible Spending Account (FSA), if elected.

You may participate in the Flexible Spending Plan even if you do not elect coverage under MedCath Incorporated Health Benefits Plan.

In order to provide you with the tax savings advantage of the Flexible Spending Plan the Federal government requires that the benefit options you elect remain unchanged throughout that year, except in the case of a qualified status change, as defined below.

**Failure to Elect**

**New Employee**

If you are a newly eligible Employee and you do not submit your completed election form by the date required by Human Resources you are, by this action,
electing to not participate in the Plan and no FSA will be set up for you.

Existing Employee

If you are currently participating in the Flexible Benefits Plan and fail to complete an election form during open enrollment for the coming year, the following will occur:

- Your Premium Conversion Plan contributions, if any, will be continued.
- You will not be enrolled in any Flexible Spending Account options.

Status Change

You may change the choices you have made for the current year for your premium conversion election, dependent care FSA, or revoke your health care FSA entirely, only if (1) you experience any of the following qualified status changes, (2) the change in your election is consistent with such status change, to the extent that it is necessary or appropriate as a result of the change, and (3) you submit a timely request, generally within 30 days, for a change in benefits:

- Special Enrollment rights
  - Termination of other coverage (including exhaustion of COBRA benefits).
  - The end of all employer contributions toward the other coverage.
  - Legal separation or divorce.
  - Termination of other employment or reduction in number of hours of other employment.
  - Death of covered person.
  - Termination of extended benefits that were provided due to any of the situations above.
- Change in marital status
- Change in your number of dependents
- Change in your employment status or that of your spouse or dependent
- Loss of Dependent eligibility – due to age, student status, etc.
- Change in residence
- Qualified leave, per the Family and Medical Leave Act (FMLA) – a group health plan change
- Significant cost or coverage change to a health plan – for you or your spouse
- Judgment, decree or order, such as a Qualified Medical Child Support Order (QMCSO)
- Entitlement to Medicare and Medicaid – a group health plan change
- Changes in cost or coverage:
  - If your share of the premium under the group health plan increases (or decreases) during the Plan Year, the election amount for the group health plan shall be automatically increased or decreased.
  - If the cost of the group health plan significantly increases, you may revoke your election with respect to the group health plan only to elect a plan with similar coverage.
  - If the cost of your dependent care expenses increase or decrease, and the cost change is imposed by a dependent care provider who is not your relative, you may change the deduction for dependent care assistance for the balance of the Plan Year.
  - If the coverage under a group health plan is significantly curtailed or ceases during a period of coverage you may revoke your election with respect to the group health plan only to elect a plan with coverage similar to that of your plan before it was modified.
  - If during a Plan Year your Employer adds a new benefit package option or other coverage option, you may, if you are currently enrolled, elect the newly added option and make corresponding election changes with the respect to other benefit package options under the group health plan.
  - You may make an election change during a Plan Year that is on account of and corresponds with a change made under the plan of your spouse, former spouse or dependent’s employer if (1) a cafeteria plan of such spouse, former spouse or dependent permits you to make an election change or (2) such other cafeteria plan permits you to make an election for a period of coverage that is different from a period of coverage under this Plan.

Inactive Employee

Leave of Absence

If you experience an absence from work due to an approved unpaid leave, such as leave under the Family Medical Leave Act of 1993 (FMLA), and
leave under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employer will offer continuation of your health care FSA on the same terms and conditions as though you were an active Employee. You must continue to make contributions to the FSA, as you would have done as an active Employee through payroll deductions.

The Plan Administrator will assist you in arranging to make contributions to your health care FSA. You may pay with after-tax dollars while you are on leave, you might choose to pre-pay your costs in pre-tax dollars before an anticipated leave, or make another arrangement with the Plan Administrator.

(You may refer to the Employer’s leave of absence policy for specific information regarding approval and length of continuation.)

Short-Term Disability/Long-Term Disability

If you experience a leave from work due to a qualifying short-term disability or long-term disability the Employer will offer continuation of your elected health plan coverage, and FSA options on the same terms and conditions as though you were an active Employee.

The Plan Administrator will assist you in arranging to make your contributions on a monthly basis during your disability leave, or to make up your contributions upon return to work.

Return to Work

When you return from an approved unpaid leave of absence you will be permitted to resume your Premium Conversion Plan contributions on the same basis as before your leave.

If you return within the same Plan Year any previous contributions to an FSA will resume automatically.

If you do not return from FMLA leave within the same Plan Year your contributions to your dependent care FSA will continue to be suspended.

All provisions of this Plan related to USERRA or FMLA will be administered as required by Federal regulations. See your MedCath Incorporated Group Health Benefits Plan Document for more information, or discuss your specific situation with your Human Resources representative.

Reinstatement

Participation in an FSA may not be reinstated within the same Plan Year.

Participation in the Premium Conversion Plan may be reinstated when the Employer offers you the choice to reinstate the Premium Conversion Plan option.

Termination of Participation

Your participation in the Plan will terminate when:

- You are no longer an eligible Employee
- You no longer satisfy the conditions for participation in the Plan
- You revoke all elections under the Plan due to a status change
- The Plan terminates
- You are deceased.

When your participation in the Plan terminates for any reason, or you revoke your election under the provisions described in Participation, Status Change, your salary reductions will terminate.

- You may continue to claim reimbursement from an FSA, for up to three months from your date of termination, for any eligible expenses incurred on or before the date your participation terminated up to.
- You will not be able to receive reimbursements from an FSA for expenses that are incurred after your participation terminates.
- You may qualify for COBRA continuation of an existing health care FSA, however, the cost of such continuation may not be paid/contributed on a pre-tax basis.

A health care FSA may only be continued if the amount of your elected Plan Year contribution that is available to be reimbursed during the remainder of the Plan Year is greater than the total contribution required, based on that election, for the remainder of the Plan Year.

See your MedCath Incorporated Group Health Benefits Plan Document for additional information on COBRA continuation.

- You may not continue a dependent care FSA under the provisions of COBRA continuation.

When your participation in the health care FSA is terminated due to your failure to make the required contribution, you may not make a new health care FSA election for the remaining portion of the Plan Year.

Plan Compliance

The Plan will make any necessary amendments to the Flexible Benefits Plan that are required to maintain compliance with Federal regulations.
You may be required to make changes in your benefit elections as a result of this action, such as reducing or discontinuing your contribution to an FSA. In such event, the Plan Administrator will make the necessary adjustments to your salary reduction amounts for the remainder of the Plan Year.

**GENERAL PROVISIONS**

**Plan Administration**

The Plan is administered through the Human Resources Department of MedCath Incorporated. MedCath Incorporated is the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the Plan.

Each Flexible Spending Account (FSA) is administered by MedCath Incorporated in accordance with federal regulations, with no administrative cost to the Employee. Any forfeited funds may be used by the Employer, at its discretion, to pay for administration of the Plan, to offset distributions from health care accounts that exceed contribution, or for redistribution to all contributors.

**Plan is not an Employment Contract**

The Plan is not a contract between the Employer and Employee or an inducement or condition of employment. Nothing in the Plan gives any Employee the right to retain Employee status or to interfere with the right of the Employer to terminate the employment of any Employee at any time.

**Plan Changes**

The Employer reserves the right to amend the Plan at its sole discretion. The Employer will communicate to you in writing regarding any such changes that affect you.

Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with the Employer, or a written copy will be kept with the master copy of the Plan.

**Plan Termination**

The Employer reserves the right to terminate the Plan at any time, and will communicate this action to you.

In the event the Plan is terminated, you may continue to submit timely requests for reimbursement from your FSAs to recover any remaining balance, as provided in Spending Accounts, Reimbursement.

**Section 125**

This booklet constitutes a plan document under section 125 of the Internal Revenue Code ("Code"). The portions of this document related to reimbursement of health expenses constitute a medical expense reimbursement plan under section 105 of the Code. The portions of this document related to reimbursement of dependent care expenses constitute a separate written plan under section 129 of the Code. The benefits payable hereunder are intended to be excludable from the participant's gross income under sections 105, 106 and 129 of the Code, and this plan document shall be interpreted to the maximum extent to provide this intended effect.

**Tax Benefits**

The Employer bears no responsibility for and makes no warranties regarding any personal income tax filings, such as eligibility of any personal expenses for credits or deductions. It is your responsibility to determine what expenditures are eligible under Federal, state or local income tax regulations.

**Death**

Any benefit payments, or FSA reimbursements payable to you under the Plan after your death will be paid to your surviving spouse. Eligible requests may be submitted after your death. In the case of no surviving spouse any payments will be paid to your estate or designated beneficiary.

**Incapacitation**

The Plan Administrator may direct any reimbursement to your legal representative, relative or friend, or in any other manner that the Plan Administrator considers appropriate on your behalf if you are under a legal disability or, in the opinion of the Plan Administrator, you are incapacitated so as to be unable to submit a proper reimbursement request from your FSA or otherwise manage your financial affairs.

**Benefits Not Transferable**

Except as otherwise stated herein, no person other than a participating Employee is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

**Clerical Error**

No clerical error on the part of the Employer or Plan Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any Employee hereunder, nor create or continue participation which would not otherwise validly become effective or continue in force hereunder. An
 equitable adjustment of contributions and/or reimbursements will be made when the error or delay is discovered. However, if more than ninety (90) days has elapsed after the end of a Plan Year prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

Conformity with Statute(s)

Any provision of the Plan that is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

Effective Date of the Plan

The Effective Date of the modifications contained herein is July 1, 2002.

Incontestability

All statements made by the Employer or by the Employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the Employee, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Actions

No action at law or in equity shall be brought to recover on the FSA reimbursements from the Plan after the expiration of ninety (90) days following the end of the Plan Year, unless otherwise provided by applicable law.

Limits on Liability

Liability hereunder is limited to the services and benefits specified, and the Employer shall not be liable for any obligation of the Employee incurred in excess thereof. The Employer shall not be liable for the negligence, wrongful act, or omission of any healthcare or dependent care provider, institution, or their employees, or any other person. The liability of the Plan shall be limited to the cost of FSA reimbursements under the provisions stated herein, and shall not include any liability for suffering or general damages.

Lost Distributees

Any reimbursement payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the Employee to whom payment is due. However, if the Employee submits a request for reimbursement for the forfeited funds within the time prescribed in Spending Accounts, Reimbursement, such funds shall be reinstated.

Misrepresentation

If the Covered Person or anyone acting on behalf of a Covered Person makes a false statement on the application for enrollment or on a reimbursement request form and any attachments, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the Employee, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Any material misrepresentation on the part of the Employee in: making application for coverage, or any application for reclassification thereof, or for service thereunder, or, establishing an FSA or seeking FSA reimbursement, shall render the benefits under this Plan null and void.

Pronouns

Any personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Plan Right to Recovery

Whenever FSA reimbursement payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever reimbursements have been made from the Plan that should not have been made, according to the terms of the Plan, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator’s own error.

Time Effective

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan Administrator.
**SUMMARY OF PLAN ADMINISTRATION**

**Name of Plan:**
MedCath Incorporated Flexible Spending Account Plan

**Name, Address and Phone Number of Employer/Plan Sponsor:**
MedCath Incorporated
10720 Sikes Place, Suite 300
Charlotte, North Carolina 28277
704.708.6610

**Employer Identification Number:**
56-1635096

**Plan Number:**
505

**Type of Plan:**
Section 125 Flexible Benefits Plan classified as a “cafeteria” plan by the Internal Revenue Code.

**Type of Administration:**
Contract administration: The processing of claims for benefits under the terms of the Plan is provided by the Employer which is referred to as the Claims Processor.

**Name, Address and Phone Number of Plan Administrator, and Fiduciary:**
Vice-President of Human Resources
MedCath Incorporated
10720 Sikes Place, Suite 300
Charlotte, North Carolina 28277
704.708.6610

**Name, Address and Phone Number of Agent For Service of Legal Process:**
Vice-President of Human Resources
MedCath Incorporated
10720 Sikes Place, Suite 300
Charlotte, North Carolina 28277
704.708.6610

**Source of Plan Contributions:**
Contributions to the Plan are obtained from the participating Employees.

**Ending Date of Plan Year:**
Premium Conversion – June 30
Health Care FSA – June 30
Dependent Care FSA – December 31

**Procedures for Obtaining Reimbursement:**
For detailed information on how to obtain reimbursement, refer to the section entitled, Spending Account, Reimbursement, and send to:
HealthSCOPE Benefits, Inc.
Attn: Flexible Spending Department
P.O. Box 2459
Little Rock, Arkansas 72203

**Statement of ERISA Rights**
Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other locations (work sites, etc.) all plan documents governing the Plan, including insurance contracts, 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.
- Obtain copies of all plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

No one, including the Employer, a union, or any other person, may fire an Employee or discriminate against an Employee to prevent the Employee from obtaining any benefit under the Plan or exercising the rights under ERISA.
If claims for benefits under the Plan are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce the rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the Plan Administrator. If a claim for benefits is denied or ignored in whole or in part, the participant may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the Plan Administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The nearest regional office is the Dallas Regional Office, 525 Griffin Street, Room 707, Dallas, Texas 75202-5025, Phone: 214/767-6831.