FLEXIBLE BENEFITS PLAN

Summary Plan Description

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About the Plan

Overview

This booklet and the Plan Information Appendix (the "Appendix") together form the Summary Plan Description for the Flexible Benefits Plan specified in the Appendix (the "Plan") as in effect on the date specified in the Appendix. The Employer named in the Appendix (the "Employer") sponsors this Plan for its eligible employees.

If you choose to participate in the Plan, any portion of the premiums specified in the Appendix for coverage not paid by the Employer will be paid with "pre-tax" dollars, unless you have signed a waiver instructing us to deduct these premiums on an after-tax basis. In addition, any premiums for individual policies paid through the Individual Health Premium Payment Feature, as specified in the Appendix, will be paid with "pre-tax" dollars, unless you have signed a waiver instructing us to deduct these premiums on an after-tax basis.

The Plan also allows you to use "pre-tax" dollars to acquire the following types of benefits:

- If the Appendix specifies, you can elect to contribute pre-tax dollars to a Health Care Flexible Spending Account and then use that Account to cover certain medical, dental, and vision care expenses for you that are not covered by insurance or other sources (including any deductibles or co-payments). You may also be reimbursed for such expenses incurred by your spouse or dependents that are not covered by insurance or other sources. If you elect to contribute to this Account, neither you nor your spouse may contribute to a Health Savings Account ("HSA") during any months of the Plan Year and, if a Grace Period applies to the Health Care Flexible Spending Account as specified in the Appendix, any months of the Grace Period (unless the balance of your Account at the end of the Plan Year to which the Grace Period relates is zero).
- If the Appendix specifies, you can elect to contribute pre-tax dollars to a Limited Health Care Flexible Spending Account. This Account works like the Health Care Flexible Spending Account described above but may only be used to reimburse certain eligible expenses as referenced in the Appendix. If you participate in a Limited Health Care Flexible Spending Account, you may also contribute to a Health Savings Account ("HSA"), if you are otherwise eligible. Your spouse will also be eligible to contribute to an HSA (although not through this Plan). (Note that you may participate in either the Limited Health Care Flexible Spending Account, or the Health Care Flexible Spending Account, but not both.)
- If the Appendix specifies, you can elect to contribute pre-tax dollars to a Dependent Care Flexible Spending Account and then use that Account to cover certain expenses involved in caring for your dependents while you are working.
- If the Appendix specifies, and you are otherwise eligible, you can elect to contribute pre-tax dollars to an HSA. The Employer will then forward these pre-tax dollars to the trustee or custodian chosen to provide the HSA.
- If the Appendix specifies, you can elect to contribute pre-tax dollars to an Individual Health Premium Account and then use that Account to cover certain individual health insurance premiums.

About the Plan (cont.)

The benefits of using "pre-tax" dollars

The advantage of using the Plan to pay your share of the benefit plan premiums or individual policy premiums, or to reimburse medical or dependent care expenses, is that your contributions to the Plan are typically taken out of your paycheck **before** FICA, federal or state income taxes are calculated, which means you pay less in taxes. If you make pre-tax contributions to an HSA, if available, those contributions are also taken out of your paycheck before FICA and federal income taxes are calculated. Pre-tax contributions to an HSA, however, may be subject to income tax in some states, and you should consult your tax advisor for more information on the state taxation of HSA contributions. Furthermore, any reimbursements paid to you from your Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, or Dependent Care Flexible Spending Account are not subject to FICA, federal or state income taxes. In most cases, the reimbursements or payments made for individual health insurance policy premiums under the Individual Health Premium Account are not subject to FICA or federal or state income taxes. Reimbursements paid to you from your HSA are also eligible for special tax treatment, as specified in the documents governing your HSA.

Things to Note

Social Security Benefits: Because the contributions you make to this Plan are not taxed as wages for Social Security purposes, your ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including your earnings history, whether you are above or below the Social Security "wage base", and what happens to the Social Security laws between now and when you retire.

Dependent Care Tax Credit: Some people may save more in taxes by paying their dependent care expenses themselves and then claiming the dependent care tax credit, rather than using the Dependent Care Flexible Spending Account. See pages 31-35 for more information.

Group Term Life Coverage: If the face amount of the group term life insurance contract(s) on your life exceed $50,000 and the cost of such coverage is paid by the Employer, the value of the coverage in excess of $50,000 will be imputed in your income in accordance with Section 79 of the Internal Revenue Code and the regulations thereunder. For purposes of this limitation, if you pay the cost of coverage on a pre-tax basis through this Plan, that coverage is considered "paid by the Employer."

About the Plan (cont.)

Coverage for Non-Tax Dependents: If you pay premiums through the Plan (including individual policy premiums through the Individual Health Premium Account or the Individual Health Premium Payment Feature) and have enrolled an individual in the coverage who is not your spouse or tax dependent, the fair market value of the coverage for such individual shall be imputed in your income as the coverage is provided. This imputation of income shall occur regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer credits. In the alternative, if you have enrolled such an individual in the coverage, the Plan Administrator may require you to pay the cost of coverage for which you are responsible on an after-tax basis up to the amount of the fair market value of the coverage provided to such individual. To the extent the cost of coverage for which you are responsible exceeds that fair market value, the remaining cost of coverage may be paid pre-tax through this Plan. To the extent the cost of coverage for which you are responsible is less than that fair market value, the excess of the fair market value over the after-tax payments will be imputed in your income as the coverage is provided.

For purpose of this Plan, the term "spouse" means an individual to whom you are legally married (under applicable state law) and who is treated as your "spouse" under the Internal Revenue Code.

For purpose of this Plan, the term "tax dependent" means an individual who satisfies the requirements of paragraph (a), (b) or (c) below:

Note: The definition "tax dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent Care Flexible Spending Account. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

(a) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and
(2) will not attain age 27 during the relevant calendar year.

(b) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;
(2) has the same principal place of abode as you for at least one-half of the relevant year;
(3) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;
(4) did not provide over half of his/her own support during the relevant year;
(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;
(6) is younger than you; and
(7) does not file a joint tax return with his or her spouse.

(c) An individual who:

(1) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;
(2) has received more than one-half of his/her support from you during the relevant year;
(3) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (a) above with respect to any person); and
(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

Illustration – Benefit of Paying Expenses with Pre-tax Dollars

Assume Mary had $400 of medical expenses during the year that were not covered by insurance. Assume also that her income tax rate (combined state and federal) for that period is 25%, and that all her pay is subject to FICA taxes.

Without the Plan – paying expenses with after-tax dollars

Mary has to earn $593.91 to have enough left after taxes to pay her $400 in medical expenses. Out of that $593.91, Mary first pays FICA tax ($593.91 x 7.65% = $45.43) and income tax ($593.91 x 25% = $148.48), leaving her with just enough to pay her $400 of medical expenses.

With the Plan – paying expenses with pre-tax dollars

If Mary had elected to contribute $400 to her Health Care Flexible Spending Account, that same $400 in medical expenses would be paid with pre-tax dollars, which means that Mary only had to earn $400 in order to have enough to pay the expenses. In other words, paying the expenses with pre-tax rather than after-tax dollars saved Mary a total of $193.91.

Note that Mary would still come out ahead even if she had contributed slightly more to her Health Care Flexible Spending Account than she actually used during the year. For example, if Mary had elected to contribute $450 to her Account, the $50 that she did not use during the year would be forfeited (unless a rollover was available under the Plan). However, Mary would still be better off compared to paying the expenses with after-tax dollars, although her overall savings would be reduced ($143.91 instead of $193.91).

Same principles apply to dependent care and premiums

Although this illustration is limited to the Health Care Flexible Spending Account, the same principles apply to the payment of eligible expenses under the Limited Health Care Flexible Spending Account and dependent care expenses and premiums using pre-tax dollars.

Your savings under the Plan

As you can see, your savings will depend upon –

1. The amount of your reimbursable expenses, and whether or not you use all of the amount credited to your Accounts.
2. Your marginal income tax rate.
3. Whether or not you have already paid the maximum FICA taxes.

About this Booklet

This booklet is a summary of the Plan. It describes the Plan provisions as in effect on the date specified in the Appendix.

Some rules were different in prior years. The rules may change again in the future.

It's only a summary

We have tried to include the information that we think is necessary for an understanding of how the Plan works. It is important to remember, however, that this booklet is only intended to be a summary and therefore provides only generalized information. A summary cannot deal with every conceivable set of circumstances.

The Plan has been established under a detailed legal document which controls the rights of participants. If this summary is inconsistent with that document in any way, the legal document will nevertheless control. Copies of the Plan document are available for your review.

This booklet is not intended to describe all of the complex rules which apply to HSAs. For more information on HSAs, refer to the documents governing those accounts.

Read the entire booklet

It is important that you read the entire booklet. Reading only portions can be confusing and misleading.

Legal requirements

The Plan has been designed to comply with current federal laws and regulations covering cafeteria plans. Congress or the IRS may make further changes in the future. The Plan, of course, must comply with any changes that occur.

Eligibility

Entering the Plan

In general, you are eligible to participate in the Plan on the entry date specified in the Appendix, provided you have submitted any required election as described below.

New Hires: If the entry date specified in the Appendix is your date of hire, you may begin participating in the Plan on your date of hire even if you do not submit the election form prior to that date. If your election is made within 30 days of your hire date, your participation will begin retroactively as of your hire date. In such case, salary reduction contributions to pay for coverage during the period preceding the date of your election to participate shall be taken prospectively from compensation paid following the election.

Covered positions

You are in a covered position if you meet the eligibility requirements for qualified employees, as specified in the Appendix.

Any individual who is classified by the Employer as an independent contractor (or as working in any other non-employee position) is not in a covered position, regardless of the correct legal status of the individual. The Plan also excludes persons classified by the Employer as temporary employees or leased employees, persons employed outside of the United States, certain non-resident aliens, self-employed individuals, and certain business owners (including sole proprietors, partners, more-than-2% shareholders of an S corporation (and certain members of such owners' families), and members of an limited liability company that is taxed like a partnership).

The eligibility of any employees who become part of a collective bargaining unit would be subject to negotiations with the representative of that unit. Such persons would not be in a covered position unless the collective bargaining agreement specifically so provides.

Eligibility to participate in a Health Savings Account

If specified in the Appendix, you may be able to make pre-tax salary reduction contributions to a Health Savings Account ("HSA") through this Plan, and/or your Employer may contribute to an HSA on your behalf. If specified in the Appendix, you must be enrolled in the high deductible health plan sponsored by the Employer in order to make contributions to your HSA through this Plan. Whether or not an HSA is made available under this Plan, you can make after-tax contributions to an HSA of your choice, assuming you meet the eligibility requirements. Consult your tax advisor for more information.

Note: Participating in the Health Care Flexible Spending Account portion of this Plan disqualifies you from contributing to an HSA during any month of the Plan Year. If a Grace Period applies to the Health Care Flexible Spending Account as specified in the Appendix, then you also will not be able to contribute to an HSA for any month during the Grace Period, unless you have a zero balance in your Health Care Flexible Spending Account as of the last day of the Plan Year to which the Grace Period relates. (See page 10 for an explanation of the Grace Period.)

For that reason, if you wish to participate in an account which allows you to pay certain healthcare costs on a pre-tax basis, and remain eligible for an HSA, you will need to participate in the Limited Health Care Flexible Spending Account instead of the Health Care Flexible Spending Account.

Note: If the Health Care Flexible Spending Account includes a rollover (as specified in the Appendix), and your Health Care Flexible Spending Account has a balance at the end of the Plan Year, will be eligible to contribute to an HSA beginning with the first month following the end of the Plan Year if the rollover is provided to the Limited Health Care Flexible Spending Account or is waived as described in the *Your Plan Elections* section.

Note: If your spouse participates in a standard health flexible spending account through his/her employer, you are ineligible to make or receive contributions to an HSA.

Your Plan Elections

Elections

During each election period you will have the following elections, to the extent the benefits described below are available under the Plan as specified in the Appendix:

- First, you automatically elect to use pre-tax dollars to pay your share of the premiums for single or family coverage under the group plans specified in the Appendix, unless you sign a waiver instructing the Employer to pay the premiums on an after-tax basis.
- Second, you can specify the dollar amount you want to contribute on a pre-tax basis to your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account, if any. The maximum amount you can contribute per year is specified in the Appendix. Amounts rolled over from a prior Plan Year, if any, do not count toward that maximum.
- Third, you can specify the dollar amount you want to contribute on a pre-tax basis to your Dependent Care Flexible Spending Account, if any. The maximum amount you can contribute is generally $5,000 per year ($2,500 per year if you are married and file a separate tax return). However, you could be subject to a smaller limit. (See pages 32-36.)
- Fourth, you can specify the dollar amount you want to contribute on a pre-tax basis to your Individual Health Premium Account, if any.
- Fifth, you automatically elect to use pre-tax dollars to pay your premiums for the individual health policies identified in the Appendix, if any, through the Individual Health Premium Payment Feature unless you sign a waiver instructing the Employer to pay the premiums on an after-tax basis.

If the Employer permits pre-tax contributions to an HSA through this Plan, as specified in the Appendix, you may also elect to contribute to an HSA on a pre-tax basis. An election to contribute to an HSA does not have to be made in the election period. Rather, you may elect to contribute to an HSA in the month preceding the month that you wish to begin contributing to an HSA (e.g., you should file your HSA election in March if you wish to start contributing to an HSA in April). For more information regarding establishing and making contributions to an HSA, refer to the governing documents for those accounts.

Election Periods

The Plan Year and the "Annual Election Period" for each year are specified in the Appendix. Elections filed during the Annual Election Period apply to all paychecks issued during the subsequent Plan Year.

If you filed an election during a prior year and you do not file a new election during the Annual Election Period, your prior election with respect to the payment of premiums will automatically carry over to the following year. However, if you previously elected to contribute to a Health Care Flexible Spending Account, a Limited Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, or an Individual Health Premium Account, that election **will not** carry over. If you want to continue to contribute to those Accounts you must make a new election.

The Plan also has several "Special Election Periods:"

- If you become eligible to participate in the Plan in the middle of the year, the 30-day period preceding your entry date (as specified in the Appendix) is a Special Election Period for all of your elections.
- If you meet the requirements for changing one or more of your elections during the Plan Year, the 30-day period immediately thereafter is a Special Election Period. (See pages 14-18.)

Elections are generally irrevocable during the year

Once you have made (or are deemed to have made) your elections to pay premiums using pre-tax dollars or to contribute to a Health Care Flexible Spending Account, a Limited Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, or an Individual Health Premium Account, you **cannot change or revoke** your elections for the remainder of the year except in very limited circumstances. (See pages 14-18.) (Elections to contribute to an HSA, if available under the Plan, are generally revocable, as explained below.)

Unless you fit those limited circumstances and make a new election, the amount you initially elect to contribute to your Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Individual Health Premium Account will be deducted from your pay for the rest of the year (even if you decide that you no longer need any additional credits to your Accounts) and your pre-tax premium payments will be deducted from your pay for the entire year (even if you decide to drop the coverage in the middle of the year). Therefore, you should use care in making your elections.

Grace Period for Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account

If you do not use the entire balance in your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account by the end of the Plan Year, you may use the remaining balance during the "Grace Period" – the period running 2 months and 15 days after the end of the Plan Year. The Grace Period only applies if specified in the Appendix. The Grace Period does not apply to the Dependent Care Flexible Spending Account or the Individual Health Premium Account.

Here is how the Grace Period works:

- Rules for Reimbursement. You may be reimbursed for eligible expenses you incur under either the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account during the Grace Period. The rules for reimbursement are the same as the rules in effect during the Plan Year.

- Deadline for Reimbursement. All claims incurred during the Grace Period must be submitted prior to the deadline for filing reimbursement requests described below. The Grace Period does not extend the claim submission deadline.

- Interaction of the Grace Period with the Plan Year. If you incur expenses during a Plan Year that runs concurrently with a Grace Period, you can decide, by checking a box on your claim reimbursement form, whether the expenses will be reimbursed from the amounts carried over into the Grace Period from the prior Plan Year or from the amounts credited to your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account for the current Plan Year. You should keep this choice in mind when estimating your expenses and making your contribution elections for each Plan Year. For example, if you think that you will have a balance to use during the Grace Period, you may not want to contribute as much to your account during a particular Plan Year. If you fail to make a choice, the expenses will be reimbursed from the amounts credited to your account for the Plan Year in which the expense was incurred.

"Use or lose"

Federal tax law imposes a "use or lose" rule on amounts contributed to your Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Individual Health Premium Account. Under this rule, you will forfeit any amounts credited to your Accounts that are not used to reimburse eligible expenses incurred during the Plan Year, or, in the case of the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account and if elected in the Appendix, the corresponding Grace Period. Unused amounts cannot be returned to you and, except as described below, cannot be rolled over to the following year.

In addition, amounts credited to your Accounts can only be used to reimburse the designated type of expenses. Your Health Care Flexible Spending Account, for example, cannot be used to reimburse dependent care expenses, or vice versa.

Therefore, you should be careful not to contribute more to your Accounts than you reasonably expect to use for eligible expenses during the year. (As shown in the Illustration on page 4, however, a small surplus will reduce your tax savings but still leave you ahead.)

The "use or lose" rule does not apply to HSA elections, if HSA contributions are permitted under the Plan, as specified in the Appendix. Instead, HSA contributions are non-forfeitable. See the documents governing the HSA for more information.

Rollover

A limited exception to the "use or lose" rule described above may apply with respect to your Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account. If the Plan does not include a Grace Period and if specified in the Appendix, a limited rollover of Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account balances from Plan Year to Plan Year will be provided in accordance with the following conditions and restrictions:

- The amount that may be rolled over is limited to the lesser of (i) $500 or (ii) the balance of your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account. The balance of the Account shall be determined upon expiration of the claims run-out period provided in the *Submitting Claims* section below.

- Although the amount of the rollover cannot be determined until the expiration of the claims run-out period, the balance of your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account as of midnight on the last day of the Plan Year, up to $500, will be available to reimburse eligible expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the claims run-out period (including allocating claims between the rollover balance and your election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

Rollovers (cont.)

- In general, a rollover occurs within the same Account. However, if the Plan includes a Limited Health Care Flexible Spending Account and unless otherwise prohibited under applicable law (including regulatory guidance), you may receive a rollover from your Health Care Flexible Spending Account to a Limited Health Care Flexible Spending Account if: (i) you enroll in the Limited Health Care Flexible Spending Account for the following Plan Year, or (ii) you direct the Plan Administrator, by no later than the last day of the Plan Year from which the rollover is to be made and in accordance with procedures adopted by the Plan Administrator, to make the rollover to the Limited Health Care Flexible Spending Account in order to maintain your (or your Spouse's) eligibility to make or receive HSA contributions.

- In general, rollovers occur automatically. However, unless otherwise prohibited under applicable law (including regulatory guidance), you may waive a rollover of your Health Care Flexible Spending Account. Such an election must be made by no later than the last day of the Plan Year from which the rollover is to be made and in accordance with procedures adopted by the Plan Administrator. The ability to waive a rollover is available only if (i) the Plan does not include a Limited Health Care Flexible Spending Account and (ii) the purpose of the waiver is to maintain your (or your Spouse's) eligibility to make or receive HSA contributions.

- Unless otherwise required under applicable law (including regulatory guidance), a rollover of a Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account balance is available only if you are eligible to make elections under the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account as of the first day of the Plan Year to which the rollover will be made (regardless of whether you actually elect to participate in the Plan).

- A rollover does not count against the maximum annual amount you may contribute to your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account as specified in the Appendix.

Employer credits to accounts

If specified in the Appendix, each Plan Year, the Employer may grant a credit to you for purposes of selecting among the benefits available under the Plan. Prior to each Plan Year, the Employer will decide whether to make such a contribution for the next year. If the Employer decides to make a contribution, the amount of such contribution will first be used to pay your group premiums. The remaining balance may then be allocated to other benefits available under the Plan (e.g., the Accounts), as specified in your election. If credits remain after allocation to your Accounts, the balance will be paid to you in cash, subject to any restrictions specified in the Appendix.

Employer contributions to HSA

If specified in the Appendix, the Employer may make contributions to an HSA on your behalf, through this Plan. Such contributions will be forwarded to the trustee or custodian providing the HSA. If specified in the Appendix, you must be enrolled in the high deductible health plan sponsored by the Employer in order to receive Employer contributions to your HSA.

Accounts are for bookkeeping purposes only

Although this booklet sometimes refers to "contributions" to your Accounts, your Accounts in the Plan exist for bookkeeping purposes only. No separate trust is created to hold the amounts by which your pay was reduced, and no money is actually set aside in any Accounts on your behalf. All medical and dependent care and individual policy premium reimbursements under the Plan are paid out of the general assets of the Employer, and you are simply a general unsecured creditor with respect to those claims. Furthermore, your Accounts do not earn interest.

Note that, unlike contributions to the Accounts, contributions to an HSA, if permitted under the Plan, are held in the trust or custodial account funding the HSA, which does earn interest, or other investment earnings.

Changing Your Elections

General rules

Once you make your elections for the year, they generally cannot be changed until the next Annual Election Period (with the exception of HSA elections, as explained on page 18). However, discussed below are several specific situations in which you are allowed to change some or all of your elections during the Plan Year.

Note: This section addresses whether you can change your elections under this Plan. If you are paying health plan premiums (e.g., medical premiums, dental premiums) through this Plan, whether you can change your coverage under the underlying health plan is determined under the terms of the applicable plan. See the separate booklet(s) describing our health care benefit program(s).

If one of these situations applies, you must make a new election within 30 days after the date of the event which permits the change and you must submit any information the Plan Administration may need to confirm that your requested election change is allowed under this Plan. Furthermore, you cannot decrease the total annual amount to be credited to your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account to less than the total amount of reimbursable claims you have already incurred prior to the new election.

If a Grace Period applies to the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account, as specified in the Appendix, you cannot change your election during the Grace Period. If, however, you changed your election during the Plan Year as a result of one of the events described below, that change will apply to the Grace Period.

If the Plan Administrator determines before or during any Plan Year the Flexible Benefits Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent or a recharacterization of benefits received under the Plan as taxable income.

In applying the following rules, except as otherwise provided below, the terms “spouse” and “dependents” have the same meanings as the definitions of “spouse” and “tax dependent” described in the *About the Plan* section above.

Changes in status

Different Personal Circumstances. The following events that occur during the Plan Year are changes in status that allow you to change any of your elections for the remainder of the year, provided your change is on account of and consistent with the event:

- A change in your legal marital status—this includes marriage, divorce, legal separation or annulment, or the death of your spouse.
- A change in the number of your dependents—this includes birth, adoption, placement for adoption, or the death of a dependent.
- A change in employment or terms of employment by you, your spouse, or your dependents. This includes beginning or ending a job, changing job classifications, or changing other terms of employment. This also includes a switch between full-time and part-time employment, and a commencement of or return from an unpaid leave of absence.
- Your dependent satisfies or ceases to satisfy the requirements for health care coverage or dependent care expense reimbursement due to a change in age, student status, disability, or any similar circumstance.
- You, your spouse or dependent change your place of residence. (For example, you move out of the service area of an HMO you elected.)

As further described below under *Consistency*, changes are allowed on account of the above-listed events only if the event has an impact upon eligibility for coverage. If there is no gain or loss of eligibility, no election change is allowed. For instance, you could experience a change in employment (e.g., a switch from full-time to part-time) that does not impact your eligibility to participate in the benefits provided through the Plan. In that case, even though a change in status has occurred, no election change will be allowed.

Different Coverage. The following events that occur during the Plan Year are changes in status that allow you to change any of your elections, except your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account elections, for the remainder of the year, provided your change is on account of and consistent with the event:

- Your coverage under our health plan[s] is significantly reduced or eliminated.
- A new coverage option is added to this Plan or our health plan[s] or an existing coverage option is significantly improved. Changing or eliminating day care providers is treated as the addition of a new coverage option to this Plan, for purposes of the Dependent Care Flexible Spending Account.
- Your spouse's or dependent's Employer's cafeteria plan, or health plan permits a change in elections due to a change in status event, general enrollment period, or other coverage change at a time that is different from this Plan's Annual Election Period and your spouse or dependent elects a change in coverage.

Change in Status (cont.)

Health Plan Premium, Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Individual Health Premium Account, and Individual Health Premium Payment Feature Elections Only. The following events that occur during the Plan Year are changes in status that allow you to change your group and individual health premium and Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, and Individual Health Premium Account elections for the remainder of the year, provided your change is on account of and consistent with the event:

- A medical child support order is issued with respect to one or more of your children (including foster children) that either requires you to purchase coverage for one or more of your children who you didn't previously cover or requires another individual to purchase coverage you were previously providing and that coverage is in fact provided.

- You, your spouse or your dependent becomes entitled to or loses eligibility for Medicare or Medicaid.

Health Plan Premium, Individual Health Premium Account and Individual Health Premium Payment Feature Elections Only. The following events that occur during the Plan Year are changes in status that allow you to change your health plan premium elections for the remainder of the year, provided your change is on account of and consistent with the event:

- You, your spouse or your dependent loses group health coverage sponsored by a governmental or educational institution.

Health Plan Premium, Health Care Flexible Spending Account, and Limited Health Care Flexible Spending Account Elections Only. The following events that occur during the Plan Year are changes in status that allow you to change your health plan premium and Health Care Flexible Spending Account, and Limited Health Care Flexible Spending Account elections for the remainder of the year, provided your change is on account of and consistent with the event:

- You take leave under the Family and Medical Leave Act and change your health plan premium, Health Care Flexible Spending Account, and/or the Limited Health Care Flexible Spending Account election as provided by that Act.

Change in Status (cont.)

Medical Plan Premium Elections Only. The following events that occur during the Plan Year are changes in status that allow you to change your medical plan premium elections for the remainder of the year (regardless of whether the consistency rules are satisfied):

- Based upon your prior employment status, you were reasonably expected to average at least thirty (30) hours of service per week and you experience a change in employment status such that after that change you will reasonably be expected to average less than thirty (30) hours of service per week (but you nevertheless will remain eligible for group medical coverage). In that situation, you may revoke your medical plan premium election if you cancel your group medical coverage (in accordance with the requirements of that plan), you and any related individuals who were also enrolled in the group medical coverage enroll in (or intend to enroll in) other medical coverage that provides minimum essential coverage, and your new coverage will be effective no later than the first day of the second month following the month in which your group medical coverage under the Employer's plan ends.

- You are eligible to enroll in a qualified health plan through the Marketplace (i.e., a public exchange) via a special enrollment period (in accordance with the Marketplace's enrollment rules) or you seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period. In that situation, you may revoke your medical plan premium election if you cancel your group medical coverage (in accordance with the requirements of that plan), you and any related individuals who were also enrolled in the group medical coverage enroll in a qualified health plan through the Marketplace, and your Marketplace coverage will be effective no later than the day immediately following the last day for which the Employer's group medical coverage was effective (i.e., you will not have a break in coverage).

Changing Your Elections (cont.)

Consistency

A change in status does not allow you to make any new election you desire. On the contrary, the change in your election(s) must be on account of and consistent with the change in status. In addition, the following consistency rules apply:

Health Plan Premiums, Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Individual Health Premium Account and Individual Health Premium Payment Feature Elections. Changes in your elections must relate to a loss or gain in eligibility for coverage under this Plan, one of our health plans, or the cafeteria or health plan of your spouse's or dependent's Employer.

For example, if you and your spouse divorce, it would be consistent with your spouse's loss of eligibility for you to reduce your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account contributions to reflect the change. However, it would not be consistent to eliminate premium payments for coverage of yourself or for other family members under our health plan (unless a medical child support order requires someone else to cover them and that coverage is in fact provided).

Dependent Care Flexible Spending Account. Changes in your elections must relate to a loss or gain in eligibility under this Plan or a change in reimbursable dependent care expenses. For purpose of the change in status events, a dependent includes any person who is a dependent for purposes of your Dependent Care Flexible Spending Account. See pages 32-33 for more information.

Effective Date of Elections. If elections are changed because of birth, adoption, or placement for adoption, the changes are effective as of the date of the event. In all other cases, the changes are effective as of the date of the election (generally, the date the election form is signed). For the effective dates described in this paragraph to apply, the election must be filed within 30 days of the event.

Premium changes

If a premium increase or decrease is not significant, the amount of your payroll deduction will be adjusted automatically to cover the change.

If there is a significant increase in the premium, you will be permitted to increase the amount of your contribution to cover the change, cancel your election of that coverage and substitute other similar coverage or, if no similar coverage is available, elect no coverage under the health plan.

If there is a significant decrease in the premium, all employees in covered positions may change their previous election and elect that coverage.

Significant change in cost of dependent care

If there is a significant increase or decrease in the cost of dependent care charged by a care provider who is not related to you, you will be permitted to increase or decrease the amount of your pre-tax contributions to your Dependent Care Flexible Spending Account to reflect the change.

Changing Your Elections (cont.)

Health Savings Accounts

If you contribute to an HSA through this Plan, the change in status rules do not apply. This is because the eligibility requirements are determined on a monthly, as opposed to a Plan Year, basis. You may start or stop your election to contribute to an HSA or increase or decrease your contribution to the HSA at any time as long as the change is effective prospectively. For example, imagine that in February, you begin contributing $100 a month to an HSA. In August, you decide that you want to increase your contributions to $150 a month and you file an election. Your contributions will increase to $150 a month for the remainder of the calendar year, beginning in September.

Paying for COBRA coverage

If you, your spouse or your dependent become eligible for COBRA continuation coverage under our health plan(s), you may increase your pre-tax premium payments to pay for the continuation coverage as long as you continue to meet the eligibility requirements under this Plan.

Special enrollment right

In certain cases, individuals are allowed to enroll in our health plans subject to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon:

- acquiring a new spouse or dependent,
- losing other group coverage if, when you, your spouse, or your dependents were first eligible for our plans, you declined coverage because you had such other coverage,
- losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and
- becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan.

(Please refer to the plan documentation for the health plan for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under that plan.)

If you, your spouse, and/or your dependent actually enroll in our health plans pursuant to HIPAA special enrollment, then you can make a mid-year election to pay the premiums for such coverage on a pre-tax basis.

Note: There are two separate steps involved in making an election change under this exception. You must enroll in the health plan within the HIPAA special enrollment time period required under that plan. You must also request a change to your election under this Plan in accordance with the general rules described above.

Submitting Claims

How your Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Individual Health Premium Account generally work

You incur the eligible expenses. You then fill out the appropriate reimbursement request form, attach proof of the services rendered and then file the form and the required substantiation with the Claims Administrator.

The Claims Administrator will make reimbursement payments within two business days of receiving your complete claim. Each time you are reimbursed, the amount credited to your Account is correspondingly reduced.

Note: If the Individual Health Premium Payment Feature is included in Plan (as specified in the Appendix), it is administered by your Employer, not the Claims Administrator. The Employer will pay the amounts withheld from your compensation directly to the insurance carrier in payment of the premium for that individual health coverage.

Electronic payment cards for the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account

If specified in the Appendix, your Employer makes available an electronic payment card (i.e., debit card) that you may use to obtain benefits under the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account, if any. The electronic payment card allows you to pay for eligible expenses at the time that you incur the expense. The electronic payment card works as follows:

You must make an election to use the card. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.

The balance of the card is limited. The balance of the card is limited to the balance of your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account.

The card will be turned off when coverage terminates. The card will be turned off when your coverage under the Plan terminates.

You must certify proper use of the card. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account will only be used for eligible expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

Electronic payment cards for the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account (cont.)

Reimbursement under the card is limited to certain places where you purchase health care related items. Use of the card is limited to merchants who: (i) have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) have the drug store or pharmacies merchant category code and with respect to whom 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code ("90% Pharmacies"); or (iii) participate in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

You swipe the card at the health care provider like you do any other credit or debit card. When you incur an eligible expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an eligible expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.

You must obtain and retain a receipt/third party statement each time you swipe the card. You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

(i) The nature of the expense (e.g. what type of service or treatment was provided);

(ii) The date the expense was incurred; and

(iii) The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for at least one year following the close of the Plan Year in which the expense was incurred. (You may desire to keep these receipts for a longer period (e.g., for purposes of an IRS audit).) Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). Also, if the expense is for an over the counter drug, the prescription for the drug will be required to be submitted. You will receive a letter from the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

Electronic payment cards for the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account (cont.)

There are situations where the third party statement will not be required to be provided to the Claims Administrator. There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:

(i) Co-Pay Match. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under the Employer's group medical plan for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.

(ii) Previously Approved Claim Match. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as an expense previously approved during the same Plan Year (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).

(iii) Provider Match Program. No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that identifies the nature of the expense and verifies the amount of the expense and that the expense is an eligible expense. This rule applies only to certain large plans.

(iv) Inventory Information Approval System. No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it and/or in the event of an IRS audit.

Electronic payment cards for the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account (cont.)

Special rules apply to the purchase of over-the-counter drugs and medicines. Notwithstanding the rules described above regarding the use of the card to purchase medical care, except for insulin (the purchase of which is subject to the rules described above), the card may be used to purchase over-the-counter drugs and medicines only in the following circumstances:

(i) At any 90% pharmacy if the expense is substantiated after the purchase by providing the third party statement as described above.

(ii) At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (1) the cardholder presents the prescription to the pharmacist; (2) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (3) the pharmacy retains a record of the transaction, including the name on the prescription, prescription number, date, and the amount of the purchase; (4) the pharmacy's records are accessible by the employer or its agent; (5) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (6) the expense is substantiated in accordance with any of the procedures described above (i.e., with or without submitting the third party statement).

(iii) At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with any of the procedures described above (i.e., with or without submitting the third party statement).

You must pay back any improperly paid claims. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. If you do not repay the Plan by the deadline set by the Claims Administrator, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law). If the Employer is unable to withhold the amount from your pay, an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, the remaining unpaid amount may be treated as an indebtedness to the Employer.

You can use either the payment card or the paper claims approach. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the paper claims approach discussed above. Claims for which the electronic payment card has been used cannot be submitted as paper claims.

Your use of the payment card is not a claim. The use of an electronic payment card does not constitute a "claim" under the claims procedures.

Submitting Claims (cont.)

If specified in the Appendix, your Employer makes available an electronic payment card (i.e., debit card) that you may use to obtain benefits under the Individual Health Premium Account, if any. The electronic payment card allows you to pay for eligible expenses at the time that you incur the expense. The electronic payment card works as follows:

(i) At the beginning of each Plan Year or, if later, when you begin participation, you must pay the initial eligible expense to the insurance carrier and submit a paper claim for such expense.

(ii) Upon substantiation of the initial eligible expense, the Plan will make available through the electronic payment card an amount equal to the lesser of: (1) the amount of the approved claim, or (2) the contributions you have made to the Individual Health Premium Account for the Pan Year to date. The electronic payment card may then be used to pay for subsequently incurred eligible expenses (e.g., the next month's premium).

(iii) Subsequent eligible expenses paid with the debit card are automatically substantiated without further review, provided (1) an electronic payment card transaction collects information that matches information for a previously approved paper claim with respect to the insurance carrier, and (2) the amount of the electronic payment card transaction is equal to or less than the previously approved paper claim. In such instances, the balance of the electronic payment card will be increased with respect to the automatically substantiated claim once the expense paid through the electronic payment card has been incurred. If an expense is not automatically substantiated in accordance with these rules, a paper claim must be submitted.

Deadline for filing reimbursement requests

Reimbursement requests for expenses incurred during a Plan Year must be filed within 90 days of the end of the Plan Year. Notwithstanding the foregoing rule, if your employment terminates during the Plan Year, a different deadline applies with respect to claims under the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account. They must be filed within 90 days following your termination of employment. Claims under the Dependent Care Flexible Spending Account and Individual Health Premium Account may be filed until the end of the normal deadline following the end of the Plan Year in which your employment terminates.

Reimbursement requests for Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account claims incurred during the Grace Period, if one applies, as specified in the Appendix, must be filed within 90 days of the end of the Plan Year (which occurs shortly after the end of the Grace Period). (See page10 for an explanation of the Grace Period.)

Reimbursement requests filed after these time periods cannot be reimbursed.

Submitting Claims (cont.)

May I submit expenses incurred before I became a Participant?	No. Only expenses incurred on or after the date you became a Participant may be reimbursed. An expense is incurred when the service is performed, not when you receive the bill or make payment.
What if I have not yet contributed enough to my Accounts via payroll deduction to cover the expenses I am submitting?	With respect to your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account, reimbursement payments will be made based on the full amount you elected to have credited to your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account for the Plan Year (plus any available rollover), even though at the time you submit your request you may not yet have contributed that much through payroll deduction. With respect to your Dependent Care Flexible Spending Account and Individual Health Premium Account (if any), you will receive a partial reimbursement based on the amount you have contributed to your Dependent Care Flexible Spending Account or Individual Health Premium Account through payroll deduction at the time you submit the expense. Additional payments will be made as additional amounts are deducted from your pay and credited to your Dependent Care Flexible Spending Account and/or Individual Health Premium Account.
Can I use my Dependent Care Flexible Spending Account to reimburse medical expenses, and vice versa?	No. As the names of the Accounts suggest, your Health Care Flexible Spending Account can only be used to reimburse eligible medical expenses; your Limited Health Care Flexible Spending Account can only be used to reimburse certain limited eligible expenses as defined in the Plan Appendix; your Dependent Care Flexible Spending Account can only be used to reimburse eligible dependent care expenses; and your Individual Health Premium Account can only be used to reimburse eligible insurance premiums.
What if I have more credited to my Accounts than I can use during the year?	Reimbursement accounts are subject to a "use or lose" rule, which means unused amounts will be forfeited. Unused amounts cannot be returned to you and, except as described in the *Your Plan Elections* section above, cannot be rolled over from one Plan Year to the next. If a Grace Period applies to the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account, as specified in the Appendix, then you may use amounts remaining at the end of the Plan Year in the Grace Period, which runs 2 months and 15 days after the end of the Plan Year. Unused amounts will be forfeited after the deadline for filing reimbursement requests described above.
Do the rules described above apply to HSAs?	No. The process for paying for qualifying expenses through an HSA is different. Claims will generally be submitted to, and reimbursed by, the trustee or custodian of the HSA account. See the separate documents governing your HSA for details.

Reviewing Health Care and Limited Health Care Flexible Spending Account Claims

Please note: the review process described below applies only to the Health Care Flexible Spending Account and Limited Health Care Flexible Spending Accounts and does not apply to Health Savings Accounts which may be offered under this Plan.

Initial Review of Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account Claims

In order to be reimbursed for eligible expenses through the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account, you must file a claim with the Claims Administrator. All claims must be filed in writing on a form supplied by the Claims Administrator within 90 days after the end of the Plan Year or 90 days following termination of employment, if earlier.

The Claims Administrator will ordinarily respond to your claim within 30 days after it is received. The initial 30-day period may be extended by the Plan for up to 15 days due to matters beyond the control of the Plan. Prior to the end of the 30-day period, the Claims Administrator will notify you of the extension, the reason for the extension and the date by which the Plan expects to decide your claim.

All notices of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on a claim, and any additional information needed to resolve the issue. If the Claims Administrator requests you to provide additional information, you will have 45 days to provide this information. Once the Claims Administrator receives the additional information or the 45-day period has passed, the Claims Administrator will have 15 days to respond to your claim.

The Claims Administrator will provide you with written notice of the benefit determination. If your benefit is denied in whole or in part, the specific reason for the denial will be provided with specific reference to any relevant Plan provisions. The notice will also provide a description of any additional material or information necessary for you to perfect a claim and an explanation of why such material or information is necessary.

Appeal of Denied Claim from Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account

If your initial claim is denied and you want to pursue the matter further, you (or your authorized representative) **must**, within 180 days after you receive the denial letter, file a written appeal with the Claims Administrator. Your written appeal should describe all reasons why you believe the claim denial was in error, and should include copies of any documents you want us to consider in support of your appeal. Your claim will be decided based on the information you submitted, so you should make sure that your submission is complete.

If you wish, you may review and/or obtain copies of all documents that the Claims Administrator considered or relied on in deciding your claim. These copies will be provided to you free of charge.

In deciding your appeal, no deference will be given to the initial adverse benefit determination. The appeal will be conducted by someone who is neither the individual who made the initial claim decision or his or her subordinate.

Reviewing Health Care and Limited Health Care Flexible Spending Account Claims (cont.)

Appeal of Denied Claim from Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account(cont.)	The Plan Administrator will ordinarily decide your appeal within 60 days after it is filed. Although the Claims Administrator processes claims and appeals, the Employer, as Plan Administrator, retains all fiduciary responsibilities with respect to the Plan, and has the exclusive final and binding authority to interpret and administer the Plan.
Do the above claims procedures apply to HSAs?	No. See the separate documents governing your HSA for the HSA claims procedures.

When Your Participation Stops

If your employment status changes so that you are no longer eligible to participate in the Plan (for example you terminate employment or you are transferred to an ineligible position), contributions to your Accounts under the Plan, pre-tax premium payments, and HSA contributions made through the Plan, if available, will generally stop.

Dependent Care Flexible Spending Account and Individual Health Premium Account

Amounts credited to your Dependent Care Flexible Spending Account and Individual Health Premium Account prior to the change in employment status will still be available for reimbursement of eligible expenses that you incur during the year, whether those expenses were incurred before or after the change in employment status. However, you cannot make any further contributions to your Dependent Care Flexible Spending Account or Individual Health Premium Account after the change.

Similarly, if you die during the Plan Year, any balance remaining in your Account may be used to reimburse eligible dependent care expenses or individual policy premiums incurred during the Plan Year, whether those expenses were incurred before or after you died.

Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account

Amounts credited to your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account prior to the change in employment status will be available for reimbursement of eligible expenses that you incurred prior to the date on which your participation ends, as provided in the Appendix.

If your employment has terminated or you have experienced a reduction in hours, you have contributed more to your Account than you have claimed as health care expenses, and if you want to use that Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account balance for expenses incurred after the date of the change in employment status and prior to the end of the Plan Year (including the Grace Period, if one applies), you are eligible for COBRA continuation coverage and you can pay the contributions on an **after-tax** basis for the remainder of the Plan Year. COBRA continuation coverage requires monthly payments equal to the applicable contribution amount (plus a 2% administrative charge). Note, in general, the plan ***is not*** subject to the full COBRA requirements if: (i) the maximum benefit payable under the Account to any Participant for a Plan Year does not exceed two times the Participant's salary reduction election for the year (or, if greater, the amount of the Participant's salary reduction election plus $500), and (ii) all employees eligible to participate in the Account are also eligible for coverage under the Employer's group health plan. If the plan is subject to the full COBRA requirements, COBRA continuation coverage is available for 18 months (instead of through the end of the Plan Year) regardless of whether you have contributed more to your Account than you have claimed as health care expenses.

Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account (cont.)

If your change in employment status is related to a military leave of absence, you may also have a right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Please contact the Plan Administrator for more information.

If you do not elect to continue contributing to your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account, you will not be reimbursed for any eligible expenses incurred after your participation ends, as provided in the Appendix.

If your coverage is in effect at the end of the Plan Year (including COBRA continuation coverage as explained above), eligible expenses incurred in the Grace Period associated with the Plan Year (if one is available, as specified in the Appendix) are eligible for reimbursement, even if your termination of employment occurs during the Grace Period.

If you die during the year, any credits remaining in your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account may be used to reimburse eligible expenses incurred prior to your death.

Health Savings Account

You are always fully vested in your HSA contributions, if any. If you terminate employment, you will not forfeit your HSA balance. If need be, you can rollover your HSA balance to another HSA when your employment ends. The documents governing the HSA should explain these rules in more detail.

Generally, you may stop contributing to an HSA at any time, even if you don't terminate employment, as long as your election to stop contributions is effective prospectively. In other words, if you want to stop contributing to your HSA in November, you should file an election to stop your contributions in October.

If you regain eligibility

If you terminate employment and are rehired in a covered position within 30 days and in the same Plan Year, any election that was in effect prior to your termination will continue in effect until the next Election Period (with an appropriate adjustment of the amount reimbursable from the Health Care Flexible Spending Account or the Limited Health Care Flexible Spending Account to reflect any contributions you did not make during your absence). If you are rehired in a subsequent Plan Year or more than 30 days following your termination of employment, you will be treated like a new employee and you will have a new election period.

Leaves of absence

If you are participating in the Plan and you take a leave of absence, you are subject to some special rules. If this affects you, please contact the Employer for more details.

Reimbursable Medical Expenses

What kind of expenses can be reimbursed out of my Health Care Flexible Spending Account?

Generally, any expenses that are considered expenses for medical care under Section 213 of the Internal Revenue Code and that have not been paid by insurance or some other source are eligible for reimbursement. For example, deductibles and co-pays and any other amounts you pay to dentists, doctors, psychiatrists, psychologists, optometrists, chiropractors, and physical therapists are all eligible for reimbursement. Also, amounts you spend for prescription drugs and medicines, contact lens solution, hearing aids, eyeglasses, x-rays, hospital fees, or any other medical expenses are covered. The costs for certain non-prescription (over-the-counter) drugs used for "medical care" (as defined under Section 213) are also considered "medical expenses." However, special rules apply.

Over-the-counter drugs and medicines (other than insulin) require a prescription as part of the claim substantiation. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and (2) that is issued by an individual who is legally authorized to issue a prescription in that state. Absent this additional claims substantiation, the expense is not reimbursable under the Health Care Flexible Spending Account.

The cost of non-prescription drugs or general health aids that are merely beneficiary to general health are generally **not** eligible medical expenses. However, certain ineligible non-prescription drugs like vitamins and dietary/nutritional supplemental may be reimbursable if you provide a prescription from your physician for the product at the time you submit the claim. The cost of personal hygiene products (such as toothpaste, cosmetics and sundry items) are not eligible medical expenses.

No premiums for insurance of any kind may be reimbursed out of your Health Care Flexible Spending Account. For example, you cannot be reimbursed for premiums owed by your spouse for any insurance provided through your spouse's Employer. (Your share of the premiums for coverage under our plans is paid directly by your pre-tax contributions under the Plan and is not paid through your Health Care Flexible Spending Account.)

What kind of expenses can be reimbursed out of my Limited Health Care Flexible Spending Account?

The expenses that can be reimbursed out of the Limited Health Care Flexible Spending Account are expenses identified in the Appendix that qualify as expenses for medical care under Code Section 213 and that have not been paid by insurance or some other source.

Reimbursable Medical Expenses (cont.)

What kind of expenses can be reimbursed out of my Limited Health Care Flexible Spending Account? (cont.)

If specified in the Appendix, "post-deductible" expenses are reimbursable under the Limited Health Care Flexible Spending Account. A "post-deductible expense" is an expense for medical care under Code Section 213, which is incurred after the minimum annual deductible applicable to HDHPs under Code Section 223(c)(2)(A)(i) has been satisfied. (See page 39 for an explanation of the HDHP.) It does not refer to the deductible under your HDHP, but rather the minimum deductible established by law, which is an indexed amount that can change from year to year. If you and/or your Spouse or Dependent has something other than single coverage under the HDHP, the applicable "minimum annual deductible" shall be the minimum deductible for family coverage. If you and/or, if applicable, your Spouse and Dependents have only single coverage under the HDHP, the applicable "minimum annual deductible" shall be the minimum deductible for self-only coverage. Only expenses that are or would be reimbursable under the HDHP in which you are enrolled are counted for purposes of determining whether you have satisfied the minimum annual deductible.

Whose expenses can be reimbursed from my Health Care Flexible Spending Account and my Limited Health Care Flexible Spending Account?

You may be reimbursed for eligible expenses incurred by you on behalf of yourself, your spouse, or your dependents. For purposes of the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account, the terms "spouse" and "dependents" have the same meanings as the definition of "spouse" and "tax dependent" described in the *About the Plan* section above.

When must expenses be incurred?

In general, you may be reimbursed from contributions made during a Plan Year only for expenses incurred during that Plan Year. Exceptions to the general rule apply if the Plan includes a Grace Period or a rollover feature as specified in the Appendix. An expense is incurred at the time the service is provided giving rise to the expense. If specified in the Appendix, a special rule applies to expenses for orthodontia care. Such expenses may be reimbursed before the orthodontia care has been provided if you have actually paid the healthcare provider in advance in order to receive the services (e.g., an upfront payment required to receive services).

What effect does reimbursement have on my medical expense deduction?

You may not claim a medical expense deduction on your income tax return for expenses that were reimbursed from your Health Care Flexible Spending Account or your Limited Health Care Flexible Spending Account. Remember, however, that most people do not qualify for the medical expense deduction because their medical expenses do not exceed the required percentage of adjusted gross income. Remember also that the amounts reimbursed to you from your Health Care Flexible Spending Account and your Limited Health Care Flexible Spending Account are not included in your gross income, so you pay no tax on that money.

Reimbursable Medical Expenses (cont.)

May I receive a distribution from Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account if I am a member of the military who is called or ordered to active duty?

You may request a "Qualified Reservist Distribution" from your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account if: (1) you are a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service; and (2) you have been ordered or called to active duty for either (i) at least 180 days, or (ii) an indefinite period of time. Such request must be made in writing on a form provided by the Plan Administrator. It must be also made on or after the date of the order or call to active duty and before the last day of the Plan Year or, if elected in Appendix, the corresponding Grace Period. A copy of the order or call to duty must accompany the form. You may receive a distribution of up to the amount contributed to the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account as of the date of the request minus any reimbursements of medical expenses provided under the account as of that date. The distribution will be included in your taxable income and will be subject to normal wage withholding requirements to the extent required by law. If a balance remains in your account following the Qualified Reservist Distribution, you may continue to submit claims for reimbursement.

Reimbursable Dependent Care Expenses

What expenses can be reimbursed out of my Dependent Care Flexible Spending Account?

Any expenses that are considered "employment-related expenses" under Section 21(b)(2) of the Internal Revenue Code are eligible for reimbursement. Generally, these expenses are expenses you incur for the care of certain "Qualifying Individuals" which are necessary to enable you (and your spouse, if you are married) to work. (See "Who are my "Qualifying Individuals"? below.)

You may use your Dependent Care Flexible Spending Account to reimburse yourself for employment-related expenses for care of your Qualifying Individuals outside your home. These expenses include the cost of food served at the care location **only if** it cannot be separated from the cost of care. These expenses include the cost of educational services **only if** the schooling is at or below the nursery school level. You will not be reimbursed from your Dependent Care Flexible Spending Account for costs of transportation to and from the care location, unless such transportation is provided by your dependent care provider. In addition, expenses for services provided by a day care center which provides care for more than six individuals may be reimbursed **only if** the center complies with all state and local rules.

You may use your Dependent Care Flexible Spending Account to reimburse yourself for the expense of services in your home if the services are at least in part for the care of a Qualifying Individual so that you (and your spouse, if you are married) may work. For example, the cost of a housekeeper, cook, or practical nurse attending to a Qualifying Individual in your home may be reimbursed. Reimbursable expenses include wages paid to the service provider, but not usual household expenses, such as the cost of food or clothing.

You will not be reimbursed from your Dependent Care Flexible Spending Account for any services provided (1) by a person with respect to whom you or your spouse could claim a deduction on your tax return, (2) by any of your children who are under age 19, (3) an individual who was your spouse at any time during the calendar year, or (4) a parent of a Qualifying Individual who is your child under age thirteen (13).

Who are "Qualifying Individuals"?

Generally, Qualifying Individuals for purposes of reimbursement from your Dependent Care Flexible Spending Account are:

1. your "qualifying child" who is under age 13;

2. your "qualifying child" or "qualifying relative" who is physically or mentally incapable of caring for himself or herself and who lives with you for more than one-half of the year; or

3. your "spouse" who is physically or mentally incapable of caring for himself or herself and if he or she lives with you for more than one-half of the year.

Who are "Qualifying Individuals"? (cont.)

Your "spouse" is an individual to whom you are legally married (under applicable state law) and who is treated as your "spouse" under the Internal Revenue Code.

Your "qualifying child" is someone who:

1. is your child (biological, adopted, foster, or stepchild), brother or sister (or stepbrother or stepsister), niece or nephew, or grandchild;

2. lives with you for more than one-half of the year;

3. has not yet turned 19 (or is a full-time student who has not yet turned 24) as of the end of that year;

4. has not provided more than half of his or her own support that year;

5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

6. is younger than you; and

7. does not file a joint federal income tax return with his or her spouse.

In the case of an individual who is totally and permanently disabled at any time during the year, the age requirement described in #3 above is deemed to be met.

Your "qualifying relative" is someone who:

1. is your child (or descendant), brother or sister (or stepbrother or stepsister), father or mother (or ancestor), stepmother or stepfather, niece or nephew, aunt or uncle, or in-law (father, mother, sister, brother, son or daughter), or is an individual who (other than a spouse) lives with you and is a member of your household (unless the relationship violates local law);

2. receives more than one-half of his or her support during the year from you;

3. is not your qualifying child or the qualifying child of any other taxpayer during the year; and

4. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

What if two people claim a child as a Qualifying Individual?

With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

Divorced or Separated Parents, or Parents Living Apart. If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year.

Other Situations. If the special rule described above regarding divorce, etc. does not apply, other special tie-breaker rules may apply. If an individual is a Qualifying Individual (under paragraphs (1) or (2) of the definition provided above) with respect to more than one person, then:

(1) If both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resides for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income).

(2) If one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent).

Reimbursable Dependent Care Expenses (cont.)

What if two people claim a child as a Qualifying Individual? (cont.)

(3) if neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income).

Important: If you enroll for dependent care benefits, it will be assumed that you are ***the one person*** entitled to treat the child as a Qualifying Individual for purposes of reimbursement under the Dependent Care Flexible Spending Account.

Are there any limits on the amount of expenses that can be reimbursed?

Yes. In any calendar year, the amount of expenses for which you are reimbursed from your Dependent Care Flexible Spending Account cannot exceed whichever of the following limits applies:

- If you are single, your net taxable pay (after all salary reductions) for the calendar year the expenses are incurred.
- If you are married and your spouse is working, your net taxable pay (after all salary reductions) or the taxable pay of your spouse, whichever is less, for the calendar year the expenses are incurred.
- If you are married and your spouse either is a full-time student for at least five months during the Plan Year or is physically or mentally incapable of caring for himself or herself, $250 in any one month if you have only one dependent or $500 in any one month if you have more than one dependent.

In addition, your reimbursement from your Dependent Care Flexible Spending Account in any calendar year cannot exceed $5,000 ($2,500 if you are married and file a separate return).

- To satisfy these limits, you should make sure that the taxable pay you actually receive in your paycheck each payroll period will always be larger than the amount that was deducted from it for your Dependent Care Flexible Spending Account. If you are married and your spouse's pay is less than your net paycheck, don't elect to contribute more than your spouse's pay (taking into consideration the special $250/$500 exception described above).

Reimbursable Dependent Care Expenses (cont.)

What effect does reimbursement have on my tax credit for dependent care expenses?

You may not claim a tax credit on your income tax return for dependent care expenses that were reimbursed from your Dependent Care Flexible Spending Account. (Remember, however, that the reimbursements are not included in your gross income.)

In addition, the amount of dependent care expenses for which you may claim a tax credit is reduced, dollar for dollar, by the amount of expenses that are reimbursed from your Dependent Care Flexible Spending Account. For example, suppose you have one dependent, you incur $8,000 of dependent care expenses in one year, and you are reimbursed under the Plan for $5,000 of those expenses. The amount of expenses otherwise eligible for the tax credit ($3,000) is reduced by the amount of expenses reimbursed from the Plan ($5,000). Therefore, in this example, you could not claim a dependent care tax credit for the year. However, if you were reimbursed from the Plan for only $1,000 of expenses, you could claim a tax credit for an additional $2,000 of expenses ($3,000 - $1,000).

In certain cases, it may be more advantageous for you to claim a tax credit for your dependent care expenses, rather than paying for those expenses through the Dependent Care Flexible Spending Account. You should consult your tax advisor for further details.

What information do I need to report on my income tax return?

In order to claim the exclusion from income for expenses reimbursed from your Dependent Care Flexible Spending Account, you must report the correct name, address, and taxpayer identification number of your dependent care provider on your income tax return. (If your provider is a tax-exempt organization, you only need to report its name and address.) You should make sure that you always obtain this information from each dependent care provider you use.

Are there other limits that may apply to me?

It is possible that the amount you can contribute to your Dependent Care Flexible Spending Account may be restricted if you are a "highly compensated employee" or owner under the tax laws. If certain limits in the tax laws are exceeded, the credits to your Account may have to be reduced (or treated as taxable income to you if you have already received benefit payments).

Reimbursable Individual Policy Premiums Under the Individual Health Premium Account

What kind of premiums can be reimbursed out of my Individual Health Premium Account?

In general, you may receive reimbursements for premiums for certain individual insurance policies of the type identified in Appendix. The individual insurance policy must meet all of the following requirements:

(i) You must obtain the individual policy.

(ii) The policy must not violate the terms of the Plan and/or the requirements under the Internal Revenue Code. Policies that do not satisfy this condition include, but are not limited to, policies that defer compensation from one year to another year.

In addition to premiums for the individual insurance policies described above, if specified in the Appendix, you may also receive reimbursements for premiums for Medicare Part B, Medicare Part D, and a Medicare supplement policy in certain cases. Such coverages are eligible for reimbursement under the plan **only if** you are not eligible for coverage under any group medical plan sponsored by the Employer.

What kind of premiums can NOT be reimbursed out of my Individual Health Premium Account?

Premiums for the following individual insurance policies or coverages are not eligible for reimbursement out of your Individual Health Premium Account:

(i) Premiums for Medicare (e.g., Part B and Part D) and Medicare supplement coverages if you are eligible for the Employer's group medical plan (if any);

(ii) Premiums for policies of a type not specified in the Appendix (e.g., medical insurance policies);

(iii) Premiums for group coverage provided under another employer's plan (e.g., COBRA continuation coverage, retiree coverage, etc.); and

(iv) Premiums for policies obtained through a public insurance exchange.

Whose expenses can be reimbursed from my Individual Premium Account?

Generally, you may be reimbursed for premiums incurred for an insurance policy that covers you and your spouse and/or dependents. For purposes of the Individual Health Premium Account, the terms "spouse" and "dependents" have the same meanings as the definition of "spouse" and "tax dependent" described in the *About the Plan* section above. If the individual policy covers someone other than you and your spouse and dependents, the value of the coverage provided to such person(s) shall be included in your income as the coverage is provided.

When must expenses be incurred?

In general, you may be reimbursed from contributions made during a Plan Year only for expenses incurred during that Plan Year. An expense is incurred at the time the coverage is provided giving rise to the expense.

What effect does reimbursement have on my medical expense deduction?

You may not claim a medical expense deduction on your income tax return for expenses that were reimbursed from your Individual Health Premium Account. Remember, however, that most people do not qualify for the medical expense deduction because their medical expenses do not exceed the required percentage of adjusted gross income. Remember also that the amounts reimbursed to you from your Individual Health Premium Account usually are not included in your gross income, so you pay no tax on that money.

Individual Policy Premiums Payable Under the Individual Health Premium Payment Feature

What kind of premiums can be paid through the Individual Health Premium Payment Feature?

In general, you may pay premiums (on a pre-tax basis) for certain individual insurance policies of the type identified in the Appendix. The individual insurance policy must meet the following requirements:

(i) You must obtain the individual policy from a carrier with which your Employer has an arrangement to directly pay the premiums for the individual policy (e.g., AFLAC). The specific carrier(s) with which your Employer has such an arrangement is/are identified in the Appendix.

(ii) The policy must not violate the terms of the Plan and/or the requirements under the Internal Revenue Code. Policies that do not satisfy this condition include, but are not limited to, policies that defer compensation from one year to another year.

Note, under the Individual Health Premium Payment Feature, you will not be reimbursed for premiums. Rather, your Employer will use your pre-tax contributions to make premium payments directly to the insurance carrier.

What kind of premiums can NOT be paid through the Individual Health Premium Payment Feature?

Premiums for the following individual insurance policies or coverages cannot be paid:

(i) Premiums for Medicare (e.g., Part B and Part D) and Medicare supplement coverages;

(ii) Premiums for policies issued by a carrier other than the carrier(s) identified in the Appendix

(iii) Premiums for a policy of a type not specified in the Appendix (e.g., medical insurance policies);

(iv) Premiums for group coverage provided under another employer's plan (e.g., COBRA continuation coverage, retiree coverage, etc.); and

(v) Premiums for policies obtained through a public insurance exchange.

Who can be covered under the individual policy?

Generally, the individual policy may cover you and your spouse and/or dependents. For this purpose, the terms "spouse" and "dependents" have the same meanings as the definition of "spouse" and "tax dependent" described in the *About the Plan* section above. If the individual policy covers someone other than you and your spouse and dependents, the value of the coverage provided to such person(s) shall be included in your income as the coverage is provided

What effect does pre-tax payment have on my medical expense deduction?

You may not claim a medical expense deduction on your income tax return for premiums that were paid through the Individual Health Premium Payment Feature. Remember, however, that most people do not qualify for the medical expense deduction because their medical expenses do not exceed the required percentage of adjusted gross income.

Health Savings Account

The summary below provides a basic overview of HSAs. You should refer to the documents governing your HSA for further information.

What is an HSA?

An HSA is an account, similar to an IRA, to which an individual (or the individual's Employer) can make pre-tax or tax-deductible cash contributions. Contributions to the account may be used to pay for current and future medical expenses.

Who is eligible to contribute to an HSA?

You are eligible to contribute to an HSA if you are:

(i) Covered by a High Deductible Health Plan ("HDHP");

(ii) Not covered by other health coverage (other than specific injury coverage and accident, disability, dental care, vision care, or long-term care coverage);

(iii) Not enrolled in Medicare; and

(iv) Not claimed as a dependent on someone else's tax return.

Remember that you are not eligible to contribute to an HSA if you contribute to the Health Care Flexible Spending Account under this Plan or if your spouse is enrolled in a standard health flexible spending account through his/her employer. However, you are eligible to contribute to an HSA if you contribute to the Limited Health Care Flexible Spending Account, assuming you meet the other eligibility criteria.

What is a HDHP?

In general, a health plan qualifies as a "high deductible" health plan if it has a deductible of at least $1,300 and an out-of-pocket maximum of not more than $6,450 for single coverage, and a deductible of at least $2,600 and an out-of-pocket maximum of not more than $12,900 for family coverage.

These limits are for 2015. Thereafter, the deductible and out-of-pocket maximums are indexed for cost of living increases and may change annually. Each year, around the end of November the IRS will announce the limits which apply for the following year.

How do I contribute to an HSA?

Your Employer may offer an HSA to which you can contribute, either outside of this Plan, or, if specified in the Appendix, under this Plan, on a pre-tax basis. If specified in the Appendix, you must be enrolled in the high deductible health plan sponsored by the Employer in order to make contributions to your HSA through this Plan.

Whether or not your Employer makes an HSA available to you, you may contribute to an HSA on your own, without your Employer's involvement. In that case, you would find an HSA provider, of your choice, and arrange to contribute to the HSA. Assuming you are eligible, you can take an above the line tax deduction for such HSA contributions.

If your Employer makes an HSA available to you, review the documents governing the HSA and decide whether you wish to participate, and whether you wish to contribute on a pre-tax basis under this Plan, if that option is available to you.

If your Employer does not make an HSA available to you, you may want to decide whether you are eligible to participate in an HSA and whether you wish to participate in one before finalizing your elections under this Plan, since you will not be eligible for an HSA if you elect to participate in the Health Care Flexible Spending Account. Further, once you elect to participate in the Health Care Flexible Spending Account for a Plan Year, you will not be able to change this election unless you have a change in status in the section entitled "*Changing Your Elections*."

General Information

Name of Plan

The name of the plan is specified in the Appendix.

Type of Plan

The Plan is a cafeteria plan under Section 125 of the Internal Revenue Code, allowing a choice between cash and a variety of benefits, including but not limited to medical benefits and dependent care assistance benefits.

Plan Sponsor and Administrator

The Employer is the "Plan Sponsor" and "Plan Administrator."

Communication to the Employer as Plan Sponsor and Plan Administrator should be directed to the address and telephone number specified in the Appendix. The telephone number of the Employer is also specified in the Appendix.

Claims under the Health Care Flexible Spending Account, Limited Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Individual Health Premium Account are administered for the Employer by:

Benefit Extras, Inc.
P.O. Box 1815
Burnsville, MN 55337

Telephone: (952) 435-6858
Facsimile: (952) 435-8435

Participating Employers

The Participating Employers are specified in the Appendix.

Plan Year

The Plan Year is specified in the Appendix.

Employer Identification No.

The Employer's Federal Employer Identification Number is specified in the Appendix.

Service of legal process

Legal process may be served on the Employer or Plan Administrator at the address specified in the Appendix.

Amendment and Termination

The Employer has the right to amend or terminate the Plan at any time for any reason by action of the Employer's governing body (e.g., its Board of Directors).

Correction of errors

The Employer has the right to correct any and all errors that may occur in administering the Plan, including recovering any overpayment from the person who received it.

Assignment of Benefits

You cannot assign your benefits under this Plan to anyone else. Except in certain cases under the Individual Health Premium Payment Feature, the Plan will not reimburse anyone other than you or your estate for covered expenses. It is your responsibility to arrange for payment of those expenses and then get reimbursed from your Accounts.

No guarantee of tax consequences

The Employer is offering this Plan for its eligible employees to give them an opportunity to save money by paying certain expenses on a pre-tax basis. However, the Plan has not been approved in advance by the IRS. The Employer cannot provide any assurance or guarantee that the Plan will not be challenged by the IRS at some point.

If the IRS were to take the position that some or all of the amounts that have been deducted from your pay or expenses that have been reimbursed to you are taxable, you will be responsible for any additional taxes you owe the IRS (plus any penalties and interest), and you will not be reimbursed by the Employer. On the other hand, you will be required to reimburse the Employer for any amounts the IRS claims that should have been withheld from your pay.

HIPAA Privacy Rights

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a Federal law with many components that, among other things, protects your private health information. The HIPAA privacy rules cover the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account offered by the Employer under this Plan.

Note: The HIPAA privacy rules also apply to the group health plans (e.g., medical and dental coverage) and individual health insurance policies, the premiums for which you pay through the Plan. Your HIPAA privacy rights with respect to those plans are described in the separate plan documentation governing those plans and policies.

HIPAA protects your rights to privacy as they relate to your private health information from the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account. This private health information can include information related to a physical or mental health condition, a description of how the plan would pay for a condition, or payment for a medical condition.

Because of HIPAA, the Employer and its employees generally cannot access your private health information from the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account or distribute that information, except as authorized by you or as allowed by law. Additionally, HIPAA provides you with many rights, such as the right to request to inspect and copy your private health information. The Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account's Notice of Privacy Practices explains the Health Care Flexible Spending Account and the Limited Health Care Flexible Spending Account's obligations and your rights under HIPAA in more detail. You can obtain a copy of the Notice by contacting your Employer.

Qualified Medical Child Support Orders

In certain circumstances, you may be able to enroll one or more of your children (including foster children) in the medical reimbursement portion of the Plan by filing a Qualified Medical Child Support Order ("QMCSO") with the Employer. For more information regarding QMCSOs and the procedures for filing them with the Plan, contact the Plan Administrator.

Insurance company refunds

Any refund provided to the Employer by an insurance company that has issued an insurance contract for any component provided under the Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law. The refund will be allocated between the Employer and the Participants in accordance with the then prevailing United States Department of Labor (DOL) guidance. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the component with respect to which the refund was provided, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund or Participant premiums, a premium holiday, an increase in benefits, etc.), as determined by the Plan Administrator in it sole discretion. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

Affordable Care Act

The Health Care Flexible Spending Account and Limited Health Care Flexible Spending Account are intended to be an excepted benefit under HIPAA. Accordingly, the preventative care mandate of the Patient Protection and Affordable Care Act, as amended, does not apply to those accounts.

Statement of Rights of Participants

Note: The Flexible Benefits Plan and, if available, the Dependent Care Flexible Spending Account, the Individual Health Premium Account, the Individual Health Premium Payment Feature, and the HSAs to which contributions are made through the Plan are not subject to ERISA and this Statement of Rights of Participants does not apply to them.

As a Participant in the Health Care Flexible Spending Account or (if available) the Limited Health Care Flexible Spending Account (referred to herein generally as the "plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in the plan shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You may be able to continue health coverage if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.