# SUMMARY PLAN DESCRIPTION
# FLEXIBLE BENEFIT PLAN

**Effective January 1, 2013**

**TABLE OF CONTENTS**

INTRODUCTION

Your employer has sponsored this employee benefit program known as the Flexible Benefits Plan (the "Plan") for its employees. Under federal tax laws, it is also known as a "cafeteria plan." The Employer provides you with the opportunity to use pre-tax dollars to pay certain benefit costs by entering into a salary reduction arrangement. This arrangement is a nontaxable benefit, which should save social security and income taxes on the amount of your salary reduction. This summary describes the basic features of the Plan and how it operates. It is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. If there is a conflict between the underlying Plan and this summary, the Plan documents will govern. If you have any questions after reading this summary, please contact your Employer, as the Plan Administrator.

## GENERAL INFORMATION ABOUT THE PLAN

### 1.1 What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction and/or employer contributions, to choose (and pay for) certain benefits made available by your Employer.

### 1.2 What is the Plan Year?

The Plan operates on a 12 month Plan Year. Refer to your enrollment materials or contact your Employer as to what the Plan Year is for your entity.

### 1.3 What benefits are offered through the Plan?

Your employer has the option of offering a variety of specific benefits in this Plan, such as Group Medical, Group Dental, Group Term Life Insurance, Group Vision, Dependent Care Reimbursement, Medical Expense Reimbursement, Individual Premium Expenses, HSA Contribution Feature, Limited Scope Medical Expense Reimbursement, Employee and Dependent Only Medical Expense Reimbursement and Cash Payment. The Benefit options are described in greater detail further on in this summary. Contact your Employer for specific benefit options available under your Plan.

### 1.4 Who can participate in the Plan?

If you meet the definition of "employee" and satisfy the eligibility requirements established by your employer you may participate in the Plan. You would be considered an "Eligible Employee". Eligible Employees who participate in the Plan are called "Participants". The eligibility requirements are specified in the Plan document. Contact your Employer for eligibility requirements for participation.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. It also does not include any individual deemed by the Code to be self-employed, such as partners, shareholders of S-corporations who own more than 2% of the corporation's stock, and (in most cases) members of limited liability corporations. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

### 1.5 When do I become a Participant and how long does participation last?

If you are an Eligible Employee, the premiums withheld from your paycheck for employer sponsored group insurance benefits are automatically withheld on a pre-tax basis, unless you notify your employer in writing that you wish to discontinue the pre-tax withholding. As an Eligible Employee, you may also begin participation in the portions of the Plan offered by your Employer on the first day of the first pay period following your completion and submission of the required enrollment forms. However, you must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator. In some cases, if you do not complete the enrollment forms within that time period, you must wait until the start of a Plan Year to begin participation. Participation in the Plan continues until you elect not to participate, you are no longer an Eligible Employee, the Plan terminates, your contributions cease, or your participation is terminated for cause.

### 1.6 How do I enroll and make benefit elections?

If you become a participant other than at the start of a Plan Year, the initial enrollment period takes place at the time you become eligible to participate. The annual enrollment period ends before the first day of each Plan Year. The Plan Administrator will provide you with the forms necessary to enroll and make elections, including information about the costs of the various optional benefits.

With respect to the Optional Benefits of group medical, group dental, group term life, and group vision benefits, you are deemed to have elected to participate and to pay your share of the cost of such Optional Benefits through salary reduction unless (i) you specifically elect not to participate with respect to such Optional Benefit(s) and notify the Plan Administrator in writing on or before the start of the Plan Year, or (ii) such deemed election is otherwise prohibited by law.

With respect to the Optional Benefits of dependent care reimbursement, medical expense reimbursement, premium reimbursement for individual insurance, HSA contribution feature, limited scope medical expense reimbursement, employee and dependent only medical expense reimbursement and cash payment, you must follow the enrollment rules established by the Plan Administrator. In most instances, an affirmative election to participate is required. If the enrollment period ends and an election has not been received by the Plan Administrator, you will be deemed to have elected not to participate in the Optional Benefits involving reimbursement accounts.

NOTE: Enrollment forms received after the start of the Plan Year shall be void.

### 1.7 Can I change my election during the Plan Year?

Generally, you cannot change your election regarding participation in the Plan or the benefits you have selected during the Plan Year, although your election will terminate if you are no longer working for the Employer. You may change your elections only during the annual Enrollment Period, and then, only for the coming Plan Year. There are several exceptions to this general rule. You may change or revoke your previous election during the Plan Year if one or more of the following, significant changes in status occur:

- Change in legal marital status, including marriage, divorce, legal separation or annulment;
- Change in number of dependents;
- Termination or commencement of employment by you, your spouse or your dependent;
- A change in hours worked by you, your spouse or your dependent including, but not limited to, a switch between part-time and full-time;
- A dependent satisfies or ceases to satisfy the plan rules for dependents, such as age limit; or
- A change in place of residence or work for you, your spouse or your dependent.

If a change in status occurs, you must inform the Plan Administrator of your new election within thirty (30) days of the occurrence. Your election change must be on account of and consistent with the status change that has occurred. In general, that means the change must result in a change in coverage that changes the cost. In addition, you may be able to change your election mid-Plan Year due to the following:

- If the cost of coverage provided through insurance and paid by you through salary reduction increases or decreases, salary reductions will automatically increase or decrease in proportion to the change. If the cost of a benefit significantly increases, or if coverage under certain of the optional benefits is significantly reduced or terminated, you may be able to make a corresponding change to your election or to elect coverage under a similar optional benefit.
- If you, your spouse, or new dependent child enrolls in the group health plan due to a "special enrollment," you may be able to make a corresponding change in your election.
- If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody addresses accident or health coverage for your dependent child; you may be able to make a corresponding change in your election.
- Under certain circumstances, if the employer of your spouse or dependent changes the coverage it provides, you may be able to make a corresponding change in your election.

**NOTE**: The exceptions to the general rule that elections are irrevocable for the Plan Year are governed by regulations issued by the IRS. The Plan Administrator may modify your election downward or recharacterize some of your benefits as taxable income if necessary to prevent the Plan from becoming discriminatory within the meaning of federal income tax law.

### 1.8 Who holds the funds I have set aside under the Plan?

The funds you contribute by means of salary reduction to pay the Employee portion of the cost of coverage under the insured options will be held by the Employer until the Employer pays for such coverage. The funds you contribute by means of salary reduction to reimburse eligible medical expenses and eligible dependent care expenses are also held by the Employer, or its designee, until paid to you as a reimbursement. All held funds are the general assets of the Employer. There is no separate trust.

### 1.9 What if I terminate my employment during the Plan Year?

If your employment with your Employer terminates during the Plan Year, your active participation with this Plan ceases. You will not be able to make any more contributions for the benefits elected under this Plan, other than as may be permitted under the continuation coverage provisions that apply to group health plan coverage.

### 1.10 Will I have any administrative costs under the Plan?

Generally, no. In most instances, the Employer pays the entire cost of administering the Plan, however that is at the discretion of your Employer. Check with your Employer regarding the payment of the cost of administering the Plan.

### 1.11 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the optional benefits) indefinitely, it has the right to amend or terminate the Plan in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if any changes are made to the Plan.

### 1.12 Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are intended to not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax adviser. You should realize that any medical expense you pay or are reimbursed on a pre-tax basis under this Plan cannot be claimed as a medical expense deduction on your income tax return. Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Expense Reimbursement Plan later in this summary.

### 1.13 What is the impact on my Social Security benefits?

Because less Social Security taxes are withheld from your pay, your Social Security benefits may be affected at your retirement. However, contributions to the Plan usually have a minimal affect on your Social Security benefits.

### 1.14 How are claims determined?

**NOTE:** This claims procedure only covers claims for Dependent Care Expense, Medical Expense, Limited Scope Medical Expense, Employee and Dependent Only Medical Expense and Individual Premium Expense Reimbursement. Claims for other benefits (e.g., group medical and dental) are handled through the claims determination procedures in those separate plans.

**Claim Submission**. A Participant shall file a claim with the Claims Administrator on the required form, which will be provided by the Claims Administrator. The Claims Administrator may require the Participant to provide additional information necessary for the proper administration of this Plan.

**Determination of Benefits**. The Claims Administrator will notify you within thirty (30) days of receipt of a written claim for benefits of your eligibility or non-eligibility for benefits under the Plan. If it is determined that you are not eligible for benefits or for full benefits, the notice will set forth:

(1) the specific reasons for the denial,
(2) a specific reference to the provision of the Plan on which the denial is based,
(3) a description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is needed, and
(4) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have the claim reviewed.

If the Claims Administrator determines that there are special circumstances requiring additional time to make a decision, you will be notified of the special circumstances and the date by which a decision is expected to be made. If you are determined not to be eligible for benefits and you believe that you are entitled to greater or different benefits, you will have the opportunity to have your claim reviewed by the Plan Administrator, or Plan Administrator's designee, by filing a petition for review within one hundred eighty (180) days after you receive a notice issued by the Employer, or the Employer's designee. The petition will state the specific reasons you believe you are entitled to benefits or greater or different benefits. Within sixty (60) days after receipt of that petition, the Plan Administrator, or Plan Administrator's designee, will give you (and your counsel, if any) an opportunity to present your position to the Plan Administrator, or Plan Administrator's designee, orally or in writing, and you will have the right to review the pertinent documents. The Plan Administrator shall notify you of its decision in writing within a sixty (60) day period, stating specifically the basis of the decision. In the event of your death, the same procedures will apply to your beneficiaries.

## PART II. - GROUP BENEFITS

An important feature of the Plan is the opportunity it provides you to pay your share of the cost of specific group benefits, such as group medical, group dental, group vision and group term life insurance, on a pre-tax basis. The group benefit options under this Plan are provided through your Employer. Your share of the cost for that coverage is paid with pre-tax dollars through salary reduction under the Plan. **Note:** The Plan cannot allow the pre-tax payment of the cost of group life insurance coverage for spouse or dependents.

### 2.1 What benefits are provided?

Your employer determines what group benefits will be made available to eligible employees. Contact your employer to determine what group benefits are available to you and if you are eligible to participate in the group benefit plans.

### 2.2 How do I become a Participant?

You must satisfy the eligibility requirements of both the Plan and the Group Benefit Plan in order to be eligible to pay your share of the cost of coverage with pre-tax dollars. You must participate in the Plan in order to pay your share of the cost of coverage of with pre-tax dollars. Contact your employer for eligibility requirements for both the Plan and the Group Benefit Plan.

### 2.3 How is my portion of the cost of coverage paid?

Generally, your employer pays the amount necessary to provide the group coverage you have elected to the provider. The portion of cost of the benefit that is your responsibility may be withheld from your pay on a pre-tax basis through salary reduction under the Plan. You must be a Participant in the Plan for your portion of the premiums to be paid pre-tax.

### 2.4 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for Group Benefits, your Group Benefits stop.

### 2.5 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for Group Benefits, you and any others who receive their coverage through you ***may*** be able to continue that coverage for certain benefits. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Public Health Services Act ("PHSA"), depending upon the type of employer you work for, and applicable continuation requirements under state law. These continuation rights are described later in this summary.

### 2.6 What if I am subject to a child support order?

Notwithstanding any provision in the Group Medical Benefits portion of the Plan to the contrary, the Plan shall recognize child support orders regarding the provision of medical coverage for a child, to the extent required by applicable federal and state law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

## PART III. - DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

NOTE: Verify with your Employer that this benefit is part of your Plan.

The Dependent Care Expense Reimbursement Plan ("DC Plan") permits you to elect to receive reimbursement for some or all of your work-related dependent care expenses. Under the DC Plan, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer or you may use any available Employer Contributions. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for dependent care expenses.

### 3.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan, you may become a Participant in the DC Plan by electing benefits during your initial or subsequent annual enrollment periods.

### 3.2 What is my dependent care account?

If you elect benefits under the DC Plan, a dependent care account ("DC Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to pay with your salary reduction. Each payroll period, an amount equal to your salary reduction for that payroll period will be credited to your DC Account. The amount that is available in your DC Account at any particular time will be whatever has been credited to such DC Account less any reimbursements. The DC Account is a bookkeeping account only. The Employer pays benefits under the DC Plan from its general assets. There is no trust.

### 3.3 What are the maximum benefits I may receive?

The maximum benefit you may receive in a tax year is $5,000 if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the DC Plan, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

This maximum is reduced if any of the following situations exist:

- if you are married, reside together with your spouse, but file separate tax returns, the maximum is reduced to $2,500; or
- if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

**NOTE:** If your spouse has a dependent care program available through his or her employer, the combined total under that program and this DC Plan is the maximum described above per tax year. ***It is your responsibility to monitor your combined maximum.***

### 3.4 Who is a "qualifying individual" for whom I can claim a reimbursement?

**NOTE**: The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual.

You may be reimbursed for Eligible Expenses incurred on behalf of any individual who is either:

(a) your "child" who is under age thirteen (13);

(b) your "dependent," if your dependent is mentally or physically unable to care for himself or herself and has the same principal place of abode as you for at least one-half of the year; or

(c) your spouse, if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

"***Child***" generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person, who has the same principal place of abode as you for at least one-half of the year, and does not provide over half of his/her own support during the year.

"***Dependent***", for DC Plan purposes, generally includes (i) your "child" who has not attained age nineteen (19) during the year (age twenty-four (24) if a full-time student) and who did not provide more than half of his/her support during the relevant year, and (ii) an individual who is your child (or a descendant of a child), stepchild, eligible foster child, sibling, stepsibling, parent (or a parent's ancestor), stepparent, niece, nephew, aunt, uncle, or in-law (son, daughter, father, mother, brother, or sister) 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, who generally has received more than one-half of his/her support from you during the relevant year, and who is not a "qualifying child" (as that term is defined under Section 152 of the Internal Revenue Code) of you or someone else.

***Unless two people are married and file a joint tax return, only one person may request reimbursement of expenses incurred with respect to a particular child, even where the child satisfies the definition of "child" as to more than one person***. Special rules apply to determine which person may receive the reimbursements where more than one person wants to receive reimbursement for expenses incurred with respect to a particular child.

**Situations where both people are the child's parents who do not file a joint return (e.g., divorce or separation)**. In general, the parent who has custody for the longest period during the calendar year (i.e., the "custodial" parent) is entitled to receive reimbursement for dependent care expenses. This is true even though the non-custodial parent may be allowed to receive the child tax credit and the dependency exemption for the child on their federal income tax return. However, if the custodial parent does not claim the child as a qualifying child 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 non-custodial parent may receive reimbursement for dependent care expenses under a dependent care expense reimbursement program.

**Situations where only one or none of the people are the child's parent**. If one person is the child's parent and the other is not, the child is the qualifying individual of the parent and the parent may receive reimbursement for the child's dependent care expenses. If neither person is the child's parent, the person with the highest adjusted gross income for the year in question may receive reimbursement for dependent care expenses. However, in both cases, if the person otherwise entitled to claim the child as a qualifying individual does not claim the child as a qualifying child 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 other person may do so and receive reimbursement for dependent care expenses under the DC Plan.

If you enroll for dependent care benefits, it will be assumed that you are *the person* entitled to treat the child as a qualifying individual for purposes of reimbursement under the DC Plan.

### 3.5 What is an "Eligible Expense"?

**General Rule—Covered**. An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. Eligible Expenses generally include:

(1) Day care expenses;

(2) Cost of nursery school, preschool, or similar programs below the level of kindergarten;

(3) Cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);

(4) Cost of day camp, including specialty day camp;

(5) Cost of transportation provided by a care provider;

(6) Meals incidental to and inseparable from care;

(7) Employment taxes paid on behalf of a care provider;

(8) Cost of room and board provided to a care provider; or
(9) Certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care.

**General Rule—Not Covered**. Expenses incurred that do not enable you to be gainfully employed are generally not "eligible" including, but not limited to, expenses incurred while on vacation, sick leave, or any other type of situation where you (and your spouse) are not at work or actively looking for work (i.e., gainfully employed). Your spouse, if any, is deemed to be gainfully employed if he/she is: (1) a full time student, or (2) mentally or physically incapable of self-care and resides with you for more than one-half of the calendar year.

**Daily Allocation**. Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed. However, If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

**Who and Where Rules**. Expenses that would otherwise be "Eligible Expenses" cannot be reimbursed if they are paid to: (1) an individual who is your child under the age of nineteen (19) at the end of the calendar year; (2) an individual who is your (or your spouse's) tax dependent; (3) an individual who was your spouse at any time during the calendar year; or (iv) a parent of a Qualifying Individual who is your child under age thirteen (13).

Expenses that would otherwise be "Eligible Expenses" for services provided outside of your home may be reimbursed only if the care is for a Qualifying Individual who is: (1) your (or your spouse's) "child" under the age of thirteen (13); or (2) is another Qualifying Individual who regularly spends at least eight (8) hours per day in your home.

### 3.6 How do I receive my benefits under the DC Plan?

When you incur an expense that is eligible for payment, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your DC Account, you will be reimbursed for your Eligible Expenses at least monthly according to the schedule established by the Plan Administrator. You cannot be reimbursed for any expenses above your ***available*** DC Account balance. If your claim was for an amount that was more than your current DC Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the Effective Date of the DC Plan, for any expenses that arise before you become a Participant in the DC Plan, or for any expenses incurred after the close of the Plan Year.

**Claims Run-out Period**: You may submit claims for Eligible Expenses incurred during the Plan Year until the last day of the third calendar month following the end of that Plan Year.

### 3.7 Will I be taxed on the DC Plan benefits I receive?

You will not normally be taxed on benefits under the DC Plan. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

### 3.8 Will I still be able to claim the dependent care credit on my federal income tax return?

You may choose to participate in the DC Plan and receive credit on your federal income tax return too. However, the tax credit and the DC Account cannot be used for the same expenses. In addition, the amount of the household and dependent care credit is reduced dollar for dollar by the amount you put into your DC Account. In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the DC Account. You may want to consult your tax advisor regarding the best options under the applicable rules.

### 3.9 What is the dependent care credit?

The dependent care credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax. Please consult your tax advisor for additional information regarding how this credit would apply to your particular situation and to determine whether to participate in this DC Plan or take the dependent care credit.

### 3.10 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the DC Plan, you may not make any further contributions to your DC Account. However, you may continue to submit claims for Eligible Expenses for an eligible dependent (as described in Sections 3.4 and 3.5) until the earlier of: (i) the date your DC Account reaches zero, or (ii) the expiration of the claims run out period following the end of the Plan Year describe in Section 3.6.

### 3.11 What if the dependent care expenses I incur are less than the annual benefit I have elected?

Any amounts remaining in your DC Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year following the claims run-out period described in Section 3.6. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the annual benefit you have elected and the actual dependent care expenses you have incurred. ***If you do not use it, you lose it.***

## PART IV. - MEDICAL EXPENSE REIMBURSEMENT PLAN

NOTE: Verify with your Employer that this benefit is part of your Plan.

The Medical Expense Reimbursement Plan ("ME Plan") permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses. Under the ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer or you may use any available Employer Contributions. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses. The coverage provided through the ME Plan is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

### 4.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan you also satisfy the eligibility requirements for the ME Plan. You become a Participant in the ME Plan by electing benefits during your initial or subsequent annual enrollment periods.

**NOTE:** Participation in this ME Plan will make you ineligible to participate in the HSA Contribution Feature and will make you, your spouse and any of your dependents covered by the ME Plan ineligible to make or receive non-taxable contributions to a health savings account.

### 4.2 What is my medical expense account?

If you elect benefits under the ME Plan, a medical expense account ("ME Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the Election Form, you specify the amount of benefits you wish to pay with your salary reduction. The full amount of your election under the ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the ME Plan received during the Plan Year. The ME Account is a bookkeeping account only. Benefits under the ME Plan are paid from the Employer's general assets. There is no trust.

### 4.3 What are the maximum benefits I may receive?

The maximum annual amount of medical expense benefits per Plan Year is determined by your Employer and stated in the adoption agreement of the Plan document. Beginning with the 2013 plan year, the annual amount is limited to $2,500 (as adjusted for inflation after 2013). If you enter the plan mid-year, this maximum amount will be prorated for the number of pay periods remaining in the Plan Year.

### 4.4 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the ME Plan, your benefits under the ME Plan stop. You will have some continuation options available. If you decline the continuation options, you may not make any further contributions to your ME Account, and you may not submit claims for expenses incurred after you were terminated or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you were terminated or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described in Section 4.7.

### 4.5 Can coverage be continued?

If you terminate employment, or otherwise cease to be eligible for coverage under the ME, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Public Health Services ("PHSA"), depending upon the type of employer you work for, and applicable continuation requirements under state law. These continuation rights are described later in this summary.

### 4.6 What is an "Eligible Expense"?

**Generally**. An "Eligible Expense," in most situations, means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source. This includes expenses incurred by you (as the Participant), your spouse, or your child who also qualifies as your dependent (and not by your Spouse). For purposes of the ME Plan, Spouse means the person that is legally married to you and is treated as a spouse under the Internal Revenue Code. Dependent means (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Internal Revenue Code except that an individual's status is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code definition. See the Plan Administrator for more information about which individuals will qualify as your Dependent.

**Exceptions**. Despite the general rule stated above, an Eligible Expense does not include expenses for qualified long term care coverage; or, an expense incurred for the payment of premiums under any group or individual health plan. Many, ***but not all***, expenses that are tax deductible are also reimbursable under the ME Plan. Certain over-the-counter items are Eligible Expenses for reimbursement under the ME Plan; however are not tax deductible items. If you have a question regarding eligibility of expenses under the ME Plan, you should contact Region I.

### 4.7 How do I receive my benefits under the ME Plan?

When you incur an expense that is eligible for payment, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You will be required to submit copies of bills or receipts from the provider(s) to support your claim.

You will be reimbursed for your Eligible Expenses on a weekly basis, according to the schedule established by the Claims Administrator. Remember, you cannot be reimbursed for any expenses above the amount of your annual election. You also cannot be reimbursed for any expenses that arise before the effective date of the ME Plan, for any expenses that arise before you become a Participant in the ME Plan, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

**Claims Run-out Period**: You may submit claims for Eligible Expenses incurred during the Plan Year, and grace period if applicable, until the last day of the third calendar month following the end of that Plan Year.

### 4.8 What is a Grace Period?

"Grace Period" means the 2 ½ month period beginning after the last day of each Plan Year. If your Employer has elected the Grace Period option for the Plan, claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. Contact your Employer to determine if your Plan has the Grace Period option.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your ME Account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your ME Account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

### 4.9 What if the Eligible Expenses I incur are less than the annual benefit I elected?

Any amounts remaining in your ME Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year or following the claims run-out period described in Section 4.7. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the annual benefit you have elected and the actual medical expenses you have incurred. ***If you do not use it, you lose it.***

### 4.10 What if I am subject to a child support order?

Notwithstanding any provision in the ME Plan portion of the Plan to the contrary, the Plan shall recognize child support orders regarding the provision of medical coverage for a child, to the extent required by applicable federal and state law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

### 4.11 What if I also participate in a health reimbursement arrangement ("HRA")?

Claims for Eligible Expenses must first be submitted for reimbursement under the ME Plan. If a claim is not fully reimbursed, the balance may then be submitted under the HRA.

## PART V. - INDIVIDUAL PREMIUM PLAN

NOTE: Verify with your Employer that this benefit is part of your Plan.

The Individual Premium Plan ("IP Plan") provides an opportunity for you to pay your share of the cost of individual health insurance and certain "specialty" accident policies on a pre-tax basis. Your share of the cost of such coverage may be paid with pre-tax dollars through a salary reduction arrangement with your Employer or you may use any available Employer Contributions. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for insurance premium expenses.

### 5.1 What benefits are provided?

The benefit provided under this portion of the Plan consists of pre-tax payment of the cost of certain individual policies of insurance coverage for you (as the Participant), your spouse, or your child who also qualifies as your dependent (and not by your Spouse). For purposes of the IP Plan, Spouse means the person that is legally married to you and is treated as a spouse under the Internal Revenue Code. Dependent means (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Internal Revenue Code except that an individual's status is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code definition. See the Plan Administrator for more information about which individuals will qualify as your Dependent.

### 5.2 How do I become a Participant?

You must satisfy the eligibility requirements of both the Plan and the IP Plan in order to be eligible to pay your share of the cost of coverage with pre-tax dollars. You must participate in the Plan in order to pay your share of the cost of coverage of with pre-tax dollars. Contact your employer for eligibility requirements for both the Plan and the IP Plan.

### 5.3 What is my individual premium expense account?

If you elect benefits under this portion of the Plan, an individual premium expense account ("IP Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the Election Form, you specify the amount of benefits you wish to pay with your salary reduction. Each payroll period, an amount equal to your salary reduction for that payroll period will be credited to your IP Account. The amount that is available in your IP Account at any particular time will be whatever has been credited to such IP Account less any reimbursements. The IP Account is a bookkeeping account only. The Employer pays benefits from its general assets. There is no trust.

**NOTE:** Keep in mind the general rule regarding irrevocable elections. Unless a recognized exception to the irrevocable election rule applies, the election is irrevocable for the Plan Year; even if the underlying individual insurance policy changes or is no longer in effect.

### 5.4 What coverage can be paid pre-tax?

Not all individual policies are eligible for pre-tax payment. In order to be paid pre-tax under this portion of the Plan, an individual insurance policy must meet all of the following requirements:

1. The individual policy must be obtained by the Participant.
2. The coverage must not violate the terms of the Plan and/or the requirements under the Internal Revenue Code. This includes, but is not limited to, excluding coverage that results in deferred compensation from one year to another year.
3. "Specialty" coverages and major medical coverage are eligible. "Specialty" coverages include dental, hospital indemnity, disease specific, cancer, organ transplant coverages. ***Medicare Part B, Medicare Part D, and Medicare supplement coverages are not eligible.***

### 5.5 How do I receive my benefits under the IP Plan?

When you incur an expense that is eligible for payment, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You will be required to submit copies of bills or receipts from the provider(s) to support your claim. In some cases, certain non-group insurance premiums, such as for "Specialty" coverage, may be withheld and paid directly to the insurance carrier by the employer. If the premiums are withheld and paid directly to the insurance carrier, there is no need to submit a claim form.

If there are enough dollars credited to your IP Account, you will be reimbursed for your Eligible Expenses at least monthly according to the schedule established by the Plan Administrator. You cannot be reimbursed for any expenses above your ***available*** IP Account balance. If your claim was for an amount that was more than your current IP Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the Effective Date of the IP Plan, for any expenses that arise before you become a Participant in the IP Plan, or for any expenses incurred after the close of the Plan Year.

**Claims Run-out Period**: You may submit claims for Eligible Expenses incurred during the Plan Year until the last day of the third calendar month following the end of that Plan Year.

### 5.6 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible under the Plan, you may not make any further contributions to your IP Account. However, you may continue to submit claims for Eligible Expenses incurred while you were a Participant until the earlier of: (i) the your IP Account reaches zero, or (ii) the expiration of the claims run out period following the end of the Plan Year described in Section 5.5.

### 5.7 What if the Eligible Expenses I incur are less than my IP Account balance?

Any amounts remaining in your IP Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the annual benefit you have elected and the actual Individual Premium expenses you have incurred. ***If you do not use it, you lose it.***

### 5.8 Can coverage be continued?

**CAUTION:** This provision applies only to the extent the IP Plan is considered a group health plan for purposes of continuation coverage. If you terminate employment, or otherwise cease to be eligible for the Insurance Premium Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Public Health Services ("PHSA"), depending upon the type of employer you work for, and applicable continuation requirements under state law. These continuation rights are described later in this summary.

### 5.9 What if I am subject to a child support order?

**CAUTION:** This provision applies only to the extent the IP Plan is considered a group health plan for purposes of applicable child support laws. Notwithstanding any provision in the IP Plan portion of the Plan to the contrary, the Plan shall recognize child support orders regarding the provision of medical coverage for a child, to the extent required by applicable federal and state law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

## PART VI. - HSA CONTRIBUTION FEATURE

### 6.1 What benefits are provided?

An important feature of the Plan is the opportunity it provides you to make contributions to a health savings account ("HSA") on a pre-tax basis through the HSA Contribution Feature. In addition, the Plan also allows your Employer to make contributions to your HSA through the HSA Contribution Feature.

### 6.2 What is an HSA?

An HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) that is authorized to be the trustee of an HSA. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you. You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your Employer has no control of or responsibility for the investment of your HSA.

NOTE: If you are participating in an HSA, you may not participate in the medical expense reimbursement account portion of the flex plan. You may however, participate in the Limited Scope Medical Expense Reimbursement Plan described in PART VII below. You may not make pre-tax HSA contributions under this HSA Contribution Feature if you are covered under your spouse's health plan, are participating in the Medical Expense Reimbursement Plan, including your spouse's medical expense reimbursement plan, or are covered under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

### 6.3 How do I become a Participant?

In addition to satisfying the eligibility requirements for the Plan, you must also meet the eligibility requirements for participation in contributing to an HSA. It is the responsibility of you and your third party trustee/custodian of your HSA to ensure that you have met the eligibility requirements to contribute to an HSA. If you are eligible to participate, you become a Participant in this HSA Contribution Feature by electing benefits during your initial or subsequent annual Enrollment Periods and by providing documentation to your employer in which you certify that you are eligible to participate.

### 6.4 What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

### 6.5 When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in Plan ceases or the date you no longer satisfy the eligibility requirements described in Section 6.3. However, you need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Plan.

### 6.6 Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

### 6.7 Can participation in the HSA Contribution Feature be continued?

This HSA Contribution Feature is not subject to any laws regarding continuation rights.

### 6.8 What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

## PART VII. - LIMITED SCOPE MEDICAL EXPENSE REIMBURSEMENT PLAN

NOTE: Verify with your Employer that this benefit is part of your Plan.

The Limited Scope Medical Expense Reimbursement Plan ("Limited Scope ME Plan") permits you to elect to receive reimbursement for some of your uninsured vision and dental expenses. Under the Limited Scope ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer or you may use any available Employer Contributions. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses as defined in this portion of the Plan. You save Social Security and income taxes on the amount of your salary reduction for medical expenses. The coverage provided through the Limited Scope ME Plan is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

### 7.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan you also satisfy the eligibility requirements for the Limited Scope ME Plan. You become a Participant in the Limited Scope ME Plan by electing benefits during your initial or subsequent annual Enrollment Periods.

### 7.2 What is my limited scope medical expense account?

If you elect benefits under the Limited Scope Medical Expense Reimbursement Plan (Limited Scope ME Plan), a Limited Scope ME Account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the Election Form, you specify the amount of benefits you wish to pay with your salary reduction. The full amount of your election under the Limited Scope ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the Limited Scope ME Plan received during the Plan Year. The Limited Scope ME Account is a bookkeeping account only. Benefits under the Limited Scope ME Plan are paid from the Employer's general assets. There is no trust.

### 7.3 What are the maximum benefits I may receive?

The maximum annual amount of medical expense benefits per Plan Year is determined by your Employer and stated in the adoption agreement of the Plan document. Beginning with the 2013 plan year, the annual amount is limited to $2,500 (as adjusted for inflation after 2013). If you enter the plan mid-year, this maximum amount will be prorated for the number of pay periods remaining in the Plan Year.

### 7.4 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the Limited Scope ME Plan, your benefits under the Limited Scope ME Plan stop. You will have some continuation options available. If you decline the continuation options, you may not make any further contributions to your Limited Scope ME Account, and you may not submit claims for expenses incurred after you were terminated or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you were terminated or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described in Section 7.7.

### 7.5 Can coverage be continued?

If you terminate employment, or otherwise cease to be eligible for coverage under the Limited Scope ME, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the Public Health Services ("PHSA"), depending upon the type of employer you work for, and applicable continuation requirements under state law. These continuation rights are described later in this summary.

### 7.6 What is an "Eligible Expense"?

**Generally**. An "Eligible Expense," in most situations, means any item: (1) **for dental or vision;** (2) for which you could have claimed a medical expense deduction on an itemized federal income tax return; and (3) for which you have not otherwise been reimbursed from health coverage, or some other source. This includes expenses incurred by you (as the Participant), your spouse, or your child who also qualifies as your dependent (and not by your Spouse). For purposes of the ME Plan, Spouse means the person that is legally married to you and is treated as a spouse under the Internal Revenue Code. Dependent means (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Internal Revenue Code except that an individual's status is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code definition. See the Plan Administrator for more information about which individuals will qualify as your Dependent.

### 7.7 How do I receive my benefits under the Limited Scope ME Plan?

When you incur an expense that is eligible for payment, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You will be required to submit copies of bills or receipts from the provider(s) to support your claim.

You will be reimbursed for your Eligible Expenses on a weekly basis, according to the schedule established by the Claims Administrator. Remember, you cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that arise before the Effective Date of the Limited Scope ME Plan, for any expenses that arise before you become a Participant in the Limited Scope ME Plan, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the Limited Scope ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

**Claims Run-out Period**: You may submit claims for Eligible Expenses incurred during the Plan Year, and grace period if applicable, until the last day of the third calendar month following the end of that Plan Year.

### 7.8 What is the Grace Period?

"Grace Period" means the 2 ½ month period beginning after the last day of each Plan Year. If your Employer has elected the Grace Period option for the Plan, claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. Contact your Employer to determine if your Plan has the Grace Period option.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your Limited Scope ME Account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your Limited Scope ME Account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

### 7.9 What if the Eligible Expenses I incur are less than the annual benefit I elected?

Any amounts remaining in your Limited Scope ME Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the annual benefit you have elected and the actual medical expenses you have incurred. ***If you do not use it, you lose it.***

### 7.10 What if I am subject to a child support order?

Notwithstanding any provision in the Limited Scope ME Plan portion of the Plan to the contrary, the Plan shall recognize child support orders regarding the provision of medical coverage for a child, to the extent required by applicable federal and state law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

## PART VIII.- EMPLOYEE AND DEPENDENT ONLY MEDICAL EXPENSE REIMBURSEMENT PLAN

NOTE: Verify with your Employer that this benefit is part of your Plan.

The Employee and Dependent Only Medical Expense Reimbursement Plan ("Employee and Dependent ME Plan") permits you to elect to receive reimbursement for some for some or all of your uninsured medical expenses, provided that the expenses were incurred only by you or your child who also qualifies as your Dependent, but not your spouse. This option would typically be selected if your spouse maintains an HSA or wishes to establish an HSA. By electing the Employee and Dependent ME Plan, this leaves the option open for your spouse to make contributions to his or her own HSA. Under the Employee and Dependent ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer or you may use any available Employer Contributions. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses as defined in this portion of the Plan. You save Social Security and income taxes on the amount of your salary reduction for medical expenses. The coverage provided through the Employee and Dependent ME Plan is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

### 8.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan you also satisfy the eligibility requirements for the Employee and Dependent ME Plan. You become a Participant in the Employee and Dependent ME Plan by electing benefits during your initial or subsequent annual Enrollment Periods.

### 8.2 What is my employee and dependent only medical expense account?

If you elect benefits under the Employee and Dependent Only Medical Expense Reimbursement Plan (Employee and Dependent ME Plan), a Employee and Dependent ME Account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the Election Form, you specify the amount of benefits you wish to pay with your salary reduction. The full amount of your election under the Employee and Dependent ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the Employee and Dependent ME Plan received during the Plan Year. The Employee and Dependent ME Account is a bookkeeping account only. Benefits under the Employee and Dependent ME Plan are paid from the Employer's general assets. There is no trust.

### 8.3 What are the maximum benefits I may receive?

The maximum annual amount of medical expense benefits per Plan Year is determined by your Employer and stated in the adoption agreement of the Plan document. Beginning with the 2013 plan year, the annual amount is limited to $2,500 (as adjusted for inflation after 2013). If you enter the plan mid-year, this maximum amount will be prorated for the number of pay periods remaining in the Plan Year.

### 8.4 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the Employee and Dependent ME Plan, your benefits under the Employee and Dependent ME Plan stop. You will have some continuation options available. If you decline the continuation options, you may not make any further contributions to your Employee and Dependent ME Plan Account, and you may not submit claims for expenses incurred after you were terminated or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you were terminated or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described in Section 8.7.

### 8.5 Can coverage be continued?

If you terminate employment, or otherwise cease to be eligible for coverage under the Employee and Dependent ME Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the Public Health Services ("PHSA"), depending upon the type of employer you work for, and applicable continuation requirements under state law. These continuation rights are described later in this summary.

### 8.6 What is an "Eligible Expense"?

Generally. An "Eligible Expense," in most situations, means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source, provided that the expenses are not incurred by your spouse. This includes expenses incurred by you (as the Participant), or your child who also qualifies as your dependent (and not by your Spouse). For purposes of the Employee and Dependent ME Plan, Spouse means the person that is legally married to you and is treated as a spouse under the Internal Revenue Code. Dependent means (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Internal Revenue Code except that an individual's status is determined without regard to the gross

income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code definition. See the Plan Administrator for more information about which individuals will qualify as your Dependent.

Exceptions. Despite the general rule stated above, an Eligible Expense does not include expenses for qualified long term care coverage; or, an expense incurred for the payment of premiums under any group or individual health plan. Many, *but not all*, expenses that are tax deductible are also reimbursable under the Employee and Dependent ME Plan. Certain over-the-counter items are Eligible Expenses for reimbursement under the ME Plan; however are not tax deductible items. If you have a question regarding eligibility of expenses under the Employee and Dependent ME Plan, you should contact Region I.

### 8.7 How do I receive my benefits under the Employee and Dependent ME Plan?

When you incur an expense that is eligible for payment, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You will be required to submit copies of bills or receipts from the provider(s) to support your claim.

You will be reimbursed for your Eligible Expenses on a weekly basis, according to the schedule established by the Claims Administrator. Remember, you cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that arise before the Effective Date of the Employee and Dependent ME Plan, for any expenses that arise before you become a Participant in the Employee and Dependent ME Plan, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the Employee and Dependent ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

**Claims Run-out Period**: You may submit claims for Eligible Expenses incurred during the Plan Year, and grace period if applicable, until the last day of the third calendar month following the end of that Plan Year.

### 8.8 What is the Grace Period?

"Grace Period" means the 2 ½ month period beginning after the last day of each Plan Year. If your Employer has elected the Grace Period option for the Plan, claims incurred during the Grace Period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year. Contact your Employer to determine if your Plan has the Grace Period option.

Claims incurred during the Grace Period will be first allocated to and reimbursed from your Employee and Dependent ME Account for the preceding Plan Year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your Employee and Dependent ME Account for the current Plan Year. Claims incurred during the Grace Period will be allocated based upon the date the claim is received. Once a claim is allocated to an account, no changes, modifications, or adjustments will be allowed. In addition, no adjustment to your election for the current Plan Year may be made based upon the amount of claims incurred during the Grace Period that are reimbursed from the prior Plan Year's account.

### 8.9 What if the Eligible Expenses I incur are less than the annual benefit I elected?

Any amounts remaining in your Employee and Dependent ME Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the annual benefit you have elected and the actual medical expenses you have incurred. ***If you do not use it, you lose it.***

### 8.10 What if I am subject to a child support order?

Notwithstanding any provision in the Employee and Dependent ME Plan portion of the Plan to the contrary, the Plan shall recognize child support orders regarding the provision of medical coverage for a child, to the extent required by applicable federal and state law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

## PART IX. - CASH BENEFIT

If the Plan allows a Cash Benefit option, and the Employer makes contributions on behalf of a Participant to purchase benefits under this Plan; to the extent that the Participant does not allocate the entire Employer contribution to purchase benefits, the remainder of the unallocated Employer contribution may be paid in taxable cash to the Participant. Such payments will be made at least yearly and may

be made by a separate check or incorporated into the Participant's regular paycheck. Contact your Employer to determine if the cash benefit option is available in your Plan.

**NOTE**: Only Participants are eligible to receive a cash payment. If a Participant ceases to meet the eligibility requirements under this Plan, the cash payments shall also cease.

## PART X. - CONTINUATION COVERAGE

A Participant, and any others who are covered through that Participant, ***may*** elect to continue coverage for specific benefits under the Plan, if offered by your Employer, such as the Group Medical Benefits, Medical Expense Reimbursement Plan, Group Dental Benefits, Group Vision Benefits, Individual Premium Expense Plan, Limited Scope Medical Expense Reimbursement Plan, Employee and Dependent Only Medical Expense Reimbursement Plan, in accordance with COBRA, USERRA, and applicable state continuation laws. Contact your Employer to determine which specific benefit options listed above are available under your Plan and eligible for continuation coverage.

NOTE: If your Employer has fewer than 20 employees, your Employer is not subject to COBRA.

**COBRA Administrator:** Your Employer is responsible for administering COBRA obligations, or they may have contracted with a third party to provide assistance. Any reference within this document to "COBRA Administrator" shall mean your Employer or a third party COBRA Administrator. Please contact your Employer or its third party representative with questions, notices, and other communication regarding COBRA and the Plan.

### 10.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), including as it applies to State governmental entities through the Public Health Services Act "PHSA"), requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay the entire premium for the continuation coverage. At the end of the maximum coverage period (described below), individual conversion coverage will be offered if it is otherwise available under the Plan.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact your Employer or other third party COBRA Administrator, if designated.

This notice covers the following group health plan(s), if sponsored by your Employer. Contact your Employer for specific details regarding which group health plan(s) are covered:

- Group Medical Benefits Plan
- Medical Expense Reimbursement Plan
- Group Dental Benefits Plan
- Group Vision Benefits Plan
- Individual Premium Expense Plan
- Limited Scope Medical Expense Reimbursement Plan
- Employee and Dependent Only Medical Expense Reimbursement Plan

**Qualifying Events**. Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary." A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or placed for adoption with a qualified beneficiary ***who was the employee*** is a qualified beneficiary if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provided coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

- **Employee Loss**. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

- **Spouse's Loss**. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

    1. the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;
    2. the employee's death; or
    3. divorce or legal separation from the employee.

**NOTE**: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

- **Dependent Child's Loss**. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

    1. the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;
    2. the employee's death;
    3. divorce or legal separation of the employee and the child's other parent; or
    4. the child ceasing to be a "dependent child" under the terms of the plan.

- **Employer's Bankruptcy**. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

**Responsibility to Notify**. In certain circumstances, you are required to provide notification to the Plan in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be provided in writing and be mailed to the COBRA Administrator. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) are not acceptable. Your notice must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
(4) include a detailed description of the event;
(5) identify the effective date of the event; and
(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

Notice of Second Qualifying Event**.** In addition, the employee or a family member (of a representative acting on behalf of the employee or family member) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to your Employer. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;
(5) include a detailed description of the event;
(6) identify the effective date of the event; and
(7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

Notice of Disability. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the COBRA Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notice must be provided in writing and be mailed to the COBRA Administrator. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;
(2) state the name and address of the employee or former employee who is or was covered under the Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;
(5) state the name of the disabled qualified beneficiary;
(6) identify the date upon which the disabled qualified beneficiary became disabled;
(7) identify the date upon which the Social Security Administration made its determination of disability; and
(8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the COBRA Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the COBRA Administrator. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

**Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.**

**Election Rights**. When a qualifying event occurs, or when the COBRA Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the COBRA Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the COBRA Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

**NOTE:** Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

**NOTE:** Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

**Duration**. The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

- **Eighteen (18) Months**. If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date coverage would otherwise be lost because of the qualifying event.

- **Disability Extension**. For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

- **Pre-Qualifying Event Medicare Extension**. The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event, or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

- **Thirty-Six (36) Months**. For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the date coverage would otherwise be lost because of the qualifying event.

- **Second Qualifying Events**. If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date coverage would otherwise be lost because of the original qualifying event that triggered the continuation coverage.

**Type of Coverage**. Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

**Cost**. A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth ($18^{th}$) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

**Premature Ending**. The law provides that continuation coverage shall automatically end for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for continuation coverage is not paid on time (including any applicable grace period);
- after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any applicable pre-existing condition that you have;

**NOTE**: Under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling in the other group health plan. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month pre-existing condition waiting period expires).

- after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare;

**Notice Obligation:** The employee or a family member must notify the COBRA Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any medical benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

- with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled; or

**NOTE:** This cuts short the coverage for all qualified beneficiaries with extended coverage.

- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

**Insurability & Conversion**. A qualified beneficiary does not have to demonstrate insurability to elect continuation period. At the conclusion of the available continuation coverage, there must be an opportunity to convert to individual coverage if such coverage is offered under the Plan.

**Trade Act of 2002.** Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance ("TAA") may be eligible for a special second COBRA election and a tax credit for premiums paid for continuation coverage. TAA is generally available to those employees who have lost their jobs or suffered a reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your qualifying event.

**Address Changes:** Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately.

**More Information**: For more information about your rights under laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### 10.2 What rules apply to the Medical Expense Reimbursement Plan, Limited Scope Medical Expense Reimbursement Plan and the Employee and Dependent Only Medical Expense Reimbursement Plan, if applicable?

Modified COBRA continuation coverage rules apply to the Medical Expense Reimbursement Plan, the Limited Scope Medical Expense Reimbursement Plan and the Employee and Dependent Only Medical Expense Reimbursement Plan, if applicable as Plan options. Continuation coverage is generally available on the same terms and conditions as described above. There are, however, several differences. For example, the beginning date of the continuation coverage is earlier. If elected, continuation coverage begins on the date of the qualifying event. Furthermore, the maximum duration of the continuation coverage is much shorter. If the account is "underspent" at the time of the loss, the maximum duration of COBRA is through the end of the Plan Year in which the loss takes place. If the account is "overspent" at the time of the loss, there is no requirement that COBRA be offered.

**Underspent**. An account is UNDERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is greater than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

**Overspent**. An account is OVERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is less than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

### 10.3 What are my continuation rights for medical, dental, and vision coverage under state law?

Some states, such as Minnesota, have adopted requirements that employees and their dependents have the right to continue coverage under certain employer sponsored group medical plans. The Minnesota provisions are very similar to the federal COBRA requirements. They apply to group insurance policies, subscriber contracts and to health maintenance organization (HMO) coverages approved in Minnesota. In addition, they apply to public sector employers. They do not apply to self-funded group health plans, including Medical Expense Reimbursement Plans. There is no twenty (20) employee threshold.

Minnesota law differs from COBRA in the following situations:

(a) A former spouse and dependent children of a covered employee who were covered at the time of a marriage dissolution;

(b) A surviving spouse and dependent children with coverage at the time of the covered employee's death; and

(c) A covered employee, spouse and dependent children of the covered employee who were covered at the time the covered employee became totally disabled.

In each of these situations, there may be state continuation coverage that is more generous than COBRA, or the Public Health Services Act (PHSA) coverage for public sector employees. For example, the period of continuation coverage may be longer or the cost may be less under state continuation requirements. The continuation rights for yourself and those who are covered through you are described in the separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. If you have not been provided this information, you should contact your Employer.

### 10.4 What are my continuation and/or conversion rights for group term life insurance coverage under state law?

Not all states require continuation and/or conversion of group-term life insurance. The continuation and/or conversion rights for yourself and those who are covered through you are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact your Employer.

### 10.5 What are my continuation rights under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended, requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the USERRA Administrator.

This notice covers the following group health plan(s), if sponsored by your Employer. Contact your Employer for specific details regarding which group health plan(s) are covered:

- Group Medical Benefits Plan
- Medical Expense Reimbursement Plan
- Group Dental Benefits Plan
- Group Vision Benefits Plan
- Individual Premium Expense Plan
- Limited Scope Medical Expense Reimbursement Plan
- Employee and Dependent Only Medical Expense Reimbursement Plan

**Each person covered under the Plan(s) should read this notice carefully.**

**Service Leave Event**. If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave"), which generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

**Election Rights**. You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

**NOTE:** Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

**Duration**. The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

**Type of Coverage**. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

**Cost**. A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment. The length of the grace period will be thirty days (30), unless a longer period is provided in the insurance policy or plan document applicable to the Plan.

**Termination of the Continue Coverage**. The U-continuation coverage may be terminated for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for U-continuation coverage is not paid on time (including the grace period);
- your failure to return from service or apply for a position of employment as required under USERRA; or
- termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

**Insurability**. You do not have to demonstrate insurability to elect U-continuation coverage.

**USERRA Administrator:** Your Employer is responsible for administering USERRA obligations, unless they have contracted with a third party to provide assistance. Please contact your Employer or its third party representative with questions, notices, and other communication regarding USERRA and the Plan.

## PART XI. - FAMILY AND MEDICAL LEAVE ACT OF 1993

### 11.1 Family and Medical Leave Act of 1993

**NOTE**: If your Employer currently has fewer than 50 employees, FMLA does not apply. You will be notified if and when the Employer increases in size so as to be subject to FMLA.

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities.

**NOTE:** You should contact your Employer regarding any FMLA questions. The Claims Administrator does not have authority to make these decisions.

## PART XII. - ERISA RIGHTS

**NOTE**: If your Employer is a church or governmental entity, such as a city, county or school district, you are exempt from the Employee Retirement Income Security Act of 1974 (ERISA).

## 12.1 Statement of Rights of Covered Individuals.

If you are eligible to participate in this Plan and your Employer is subject to ERISA, you are considered a Covered Iindividual. As a Covered Individual in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Individuals shall be entitled to:

**Receive Information About Your Plans and Benefits.**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Individuals with a copy of this summary annual report (SAR), unless it is considered a "small" plan and not required.

**Small Plan Exception**: If the Plan is considered a "small" plan, the Department of Labor does not require a Form 5500 be filed. If there is no Form 5500 required to be filed, then there is no requirement to complete and distribute an SAR.

**COBRA and HIPAA Rights.**

As a Covered Individual in the Plan you are entitled to:

(a) continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights, and

(b) reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**. In addition to creating rights for Covered Individuals, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Individuals and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

**Enforce Your Rights**. If your claim for a welfare 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 thirty (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 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 domestic relations order or 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 if 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 HIPAA, 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.

## PART XIII. - ADMINISTRATIVE INFORMATION

| **Employer, Plan Administrator, and Agent for Service of Legal Process:** |
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| Your Employer is the Plan Administrator and Agent for Service of Legal Process. All questions, notices, and other communication regarding the Plan, including COBRA and applicable benefit continuation benefits available, should be directed to your Employer or its designated third party administrator, if applicable. Contact your Employer for the specific address for which all notices or correspondence should be sent. |

| **Claims Administrator:** |
|---|
| Region I is the Claims Administrator and acts as your Employer's designee with regard to administering claims for the reimbursement account portion of the Plan. All notices and correspondence regarding the claims process should be directed to : |
| Region 1<br>Flexible Benefits<br>810 4th Ave S, Suite 220<br>Moorhead, MN 56560<br><br>Phone number: 218-236-2990 or<br>Toll Free : 800-450-2990<br>Fax number: 218-236-2368 |

**This Plan does not have a trust; therefore, there are no trustees.**