VitaFlex

Fremont Union High School District
Pre-Tax Flexible Benefits Plan
Summary Plan Description

Vita Administration Company

900 North Shoreline Boulevard

Mountain View, CA 94043

VitaFlex Summary Plan Description

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VitaFlex Summary Plan Description

PART 1: IMPORTANT PLAN INFORMATION

Plan Name:	Plan Name
Plan Number:	
Initial Plan Effective Date:	
VitaFlex Effective Date:	
Plan Document Revised Date:	
FSA/DCAP Plan Year:	January 1st through December 31st
POP Plan Year:	
Employer/Plan Sponsor: (Also referred to as Your Employer)	Employer Name Address 1 Address 2 Corporate Phone Number
Employer Tax ID#:	
Affiliated Employers:	
Plan Administrator and Agent for Service of Legal Process:	Human Resources Department Employer Name Address 1 Address 2
Claims Fiduciary:	Vita Administration Company or Employer Name
Contractor for Administrative Services:	Vita Administration Company 900 North Shoreline Boulevard Mountain View, CA 94043-4680 (650) 966-1492
Plan Changes or Termination:	The Employer or Plan Administrator may terminate, suspend, withdraw, amend or modify any Plan in whole or in part at any time, subject to the corporate minutes and/or bylaws and the Code sections governing the Plan.
Waiting Period:	Employees are eligible
Eligibility Requirement:	Employees must be working at least XX hours per week.
Excluded Classes of Employees:	None
Medical Account Minimum:	$XX.XX Per Paycheck or Plan Year
Medical Account Maximum:	$X,XXX.XX Per Plan Year
Dependent Care Account Minimum:	$ XX.XX Per Paycheck or Plan Year
Dependent Care Account Maximum:	$ X,XXX.XX Per Plan Year
Flex Credit Dollars:	None
Employer Match:	None
Grace Period Provision:	Yes or No
Claims Incurred Deadline:	December 31st or March 15th (Last Day of the Plan Year)
Claims Submission Deadline:	March 31st or April 15th (following the end of the Plan Year)
Reimbursement Method:	Payroll Reimbursement, Direct Reimbursement, Employer Reimbursement
Default Plan Communication Method:	E-mail, E-mail Link, U.S. Mail
Re-Hire Election Maximum:	Plan Year or Plan Election
HEART Act	Yes or No

PART 2: INTRODUCTION

Your Employer is pleased to sponsor an employee benefit program known as the Pre-Tax Flexible Benefit Plan (the Plan) for the benefit of eligible employees. This Plan allows you to pay your premium contributions or HSA contributions on a pre-tax basis and have your medical expenses and/or dependent care expenses reimbursed on a pre-tax basis. If you wish to participate you may elect to reduce your compensation for premium contributions, eligible medical expenses, and/or eligible dependent care expenses that you expect to incur during the Plan Year. Your compensation will be reduced by that amount in lieu of receiving the money as regular pay.

Your salary reductions for premium contributions are automatically redirected to pay the necessary premiums due for the insurance coverages you have elected. There is no reimbursement for your premium contribution expenses. The required contributions are taken from your compensation as a salary reduction and are then used by Your Employer to offset a portion of the premiums for coverages you have elected. Your election to participate in the premium contribution portion of this Plan is a perpetual election and does not need to be made each Plan Year.

If applicable, you may elect to have salary reductions taken out on a pre-tax basis to pay for HSA contributions. In order to contribute to an HSA, you must be enrolled in a HSA-compatible High Deductible Health Plan. You can change your election on a prospective basis at any point in time during the Plan Year.

Your salary reductions for medical and/or dependent care expenses are allocated to your Medical Reimbursement Account and/or Dependent Care Reimbursement Account. Your Medical Reimbursement Account allocations and your Dependent Care Reimbursement allocations are *separate*. The salary reductions made to each account may not be combined in any way. Medical expenses may only be reimbursed from the Medical Reimbursement Account and dependent care expenses may only be reimbursed from the Dependent Care Reimbursement Account. Eligible expenses may not be co-mingled and contributions to the separate accounts may not be transferred. Your election to participate in the Medical Reimbursement Account or the Dependent Care Reimbursement Account must be made new each year. If you do not make a new election, your election will be deemed to be zero for both accounts.

As you incur eligible medical or dependent care expenses, you may submit claims and receive reimbursement from your Medical Reimbursement Account or your Dependent Care Reimbursement Account on a tax free basis, as allowed by federal, state, and local law. This arrangement is advantageous because the medical and dependent care expense reimbursements are nontaxable. You save Social Security and certain income taxes on your salary reduction. If you choose not to participate, you will receive the full amount of your normal compensation and it will be fully taxed as required by law.

This document describes the basic features of the Pre-Tax Flexible Benefit Plan, how it operates, how to get the maximum advantage from the Plan, and the rules and restrictions under the Plan. This document is only a summary of the key elements of the Plan. It contains a brief description of your rights as a Participant, but it is not the official Plan Document. This document is not meant to interpret, extend or change the Plan Document in any way. We suggest you read this document carefully so that you may understand the Plan's operation and its benefit to you. However, the provisions of the applicable Plans can be determined more precisely by consulting the Plan Document, which is available from your benefits administrator. *In the event of any inconsistencies or conflict between the Plan Document and this document the provisions of the Plan Document will govern.*

PART 3: GENERAL INFORMATION

Q-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 to pay for certain qualified medical and/or dependent care expenses with pre-tax dollars. This Pre-tax Flexible Benefit Plan has been established with the intention of qualifying under IRS Code §125, with Medical Reimbursements governed by IRS Code §105 ,Dependent Care Reimbursements governed by IRS Code §129, and HSA contributions governed under IRS Code § 223.. The Plan allows the value of the benefits you elect to receive to be excluded from your taxable compensation. The Plan is established for the exclusive benefit of Participants, their covered dependents, and their beneficiaries, and is administered impartially for the benefit of all eligible employees.

Q-2. What are the benefits of the Plan?

The Plan allows you to arrange a pre-tax salary reduction for certain premium contributions, medical and/or dependent care expenses. The amount you authorize to withhold from your earnings on a pre-tax basis will not count as taxable income for federal or Social Security tax purposes. In some states, state income tax is also avoided. (Question 3 illustrates an example of this savings.) The rules regarding the taxation of amounts withheld from your salary or wages for federal, state or local income tax purposes are subject to change.

Q-3. How do the tax advantages of the Plan work?

The example below shows the savings potential of someone earning $60,000 per year with $450 budgeted for medical and dependent care expenses. An annual tax savings of approximately $2,688 is available, just by participating in the Reimbursement Account Plan. The example below illustrates a conservative estimate of tax savings based on low tax rates and two exemptions. The higher your tax bracket, the more you can potentially save by participating in the Plan.

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To more accurately calculate your potential personal tax savings please refer to the VitaFlex interactive Tax Savings Calculator on the VitaFlex website at www.vitaflex.net. Click on "Tax Savings Calculator". The password is "vitaflex".

	Without Participation	With Participation
Monthly Salary	$5,000	$5,000
Actual Expenses – Funded Pre-Tax		
Premium Contributions	$ 0	$ 90
Medical	$ 0	$ 100
Dependent Care	$ 0	$ 350
Taxable Income	$5,000	$4,460
Taxes		
Federal Income Tax (25%)	$1,250	$1,115
State Income Tax (9% Estimated)	$ 450	$ 402
Social Security/Medicare Tax (7.65%)	$ 383	$ 342
	$2,083	$1,859
Income After-taxes	$2,917	$2,601
Actual Expenses – Funded After-tax		
Premium	$ 90	$ 0
Medical	$ 100	$ 0
Dependent Care	$ 350	$ 0
Take Home Pay	$2,377	$2,601
Net Pay Increase (Monthly)		$ 224
Net Pay Increase (Annual)		$2,688

Q-4. When can I start participating?

Your election becomes effective after the waiting period specified in Part 1: "Important Plan Information", assuming you have returned completed election forms or enrolled online prior to that date. You must complete your enrollment within 30 days of your initial effective date. Your enrollment process is defined by your Employer. No election may become effective until Your Employer receives your signed election form. Claims incurred prior to the date your election form is signed are not eligible, even if your normal effective date falls before that date. In order to be eligible for reimbursement, claims must be incurred after the latter of your initial eligibility date or the date you sign the election form. If your employer has a date of hire eligibility provision, your election will be effective on your date of hire as long as your election form is signed within 30 days.

Q-5. Who can participate in the Plan?

Employees who regularly and consistently work the required number of hours specified in Part 1: "Important Plan Information", and who have satisfied the required waiting period are eligible to participate in the Plan upon becoming eligible for any of the contributory health (and other) insurance benefits. Partners and 2% owners of an S-Corporation are not eligible. Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until:

(a) he or she elects not to participate in accordance with Part 3, Question 25; or
(b) he or she is no longer employed by Employer; or
(c) her or she is employed, but no longer eligible to participate in the Plan; or
(d) Continuation Coverage (described in Part 3, Question 16) is no longer in effect.

Q-6. What is a Plan Year?

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is typically January 1st through December 31st. Please refer to Part 1: "Important Plan Information" for your Employer's specific Plan Year. Should our Employer's Plan start mid-year, your Plan will run from the start date of the Plan through the end of the Plan Year as outlined in Part 1: "Important Plan Information".

Q-7. How do I become a Participant?

In any Plan Year, you will be entitled to make an election that will be effective for the entire Plan Year. You may elect by using either an Election Form, by enrolling through the VitaFlex online enrollment system, or in some cases, by enrolling through your Employer's customized benefits enrollment system. The election method(s) available to you will be outlined by your Employer. The Election Form or online election you complete identifies your elections and authorizes Your Employer to withhold an amount from your salary equal to your stated election. For Open Enrollment, you must make your elections with respect to a specific Plan Year during the Annual Open Enrollment Period immediately preceding such Plan Year. If you are a newly eligible employee, you must make your elections within 30 days of your initial eligibility date.

Your election to participate in the health plan pre-tax Premium Contribution portion of the Plan is a perpetual election. Your election to have your premium contributions taken pre-tax via salary reduction will continue with Your Employer until you expressly revoke your election. You may only revoke your election at the time of a Status Change or other permitted Change of Election. Any change in your election for pre-tax salary contributions must be in submitted in writing or in an approved electronic format and must be received by Your Employer prior to the new Plan Year for Annual Open Enrollment or within 30 days of a Status Change or other permitted Change of Election. Please note that your HSA pre-tax contribution election is not subject to the Status Change or Mid-Year Exception rules outlined in this document.

Medical and dependent care salary reduction elections require a new form or online election to be completed for each Plan Year. A new Election Form or online enrollment opportunity will be made available during the Annual Open Enrollment Period each year, and you will be required to make a new medical and/or dependent care election for the upcoming Plan Year. This election may be the same or different from the previous Plan Year. However, even if it is the same, you must complete a new election form or re-enroll online (according to your Employer's stated enrollment procedures). Any changes will become effective on the first day of the next Plan Year. If you fail to complete, sign, and return a new Election Form or make a new election online with respect to any Plan Year, your election will be deemed to be zero for both the medical and dependent care accounts for that Plan Year.

Unless you experience a Status Change or other qualified mid-year exception for another Permitted Election Change, you will not be permitted to modify your election until the next Annual Open Enrollment Period. Annual elections for participation in the Medical and Dependent Care Reimbursement Plans must be made by submitting an Election Form or making an online election within the time deadline outlined during Annual Open Enrollment prior to the beginning of each Plan Year. No deemed-elections shall occur with respect to the Medical or Dependent Care Reimbursement Plans. Your new election will become effective as of the first pay period of the Plan Year for which the election is made.

Q-8. What if I terminate my employment during the Plan Year?

If your employment with Your Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make contributions to the Plan for the period of time after your termination date. Upon your termination of employment, pre-tax salary reductions will cease. However, in some cases, a salary reduction may be made in your final paycheck (which may actually be after your date of termination) to reflect coverage prior to your termination date. Expenses will only be eligible if incurred on or before your employment termination date. Please see Q-17. "What is COBRA Continuation Coverage and how does it work?" to determine if you might be eligible for continuation coverage under COBRA.

Q-9. What are the enrollment periods for entering the Plan?

The Annual Open Enrollment Period begins approximately one to three months prior to the new Plan Year. Generally, you will receive Annual Open Enrollment Election materials between October and early December prior to the new Plan Year, depending on when your Employer has arranged the Open Enrollment period. If you do not receive these materials in a timely manner, you must request them from the Plan Administrator at least ten (10) days prior to beginning the new Plan Year.

Q-10. How are my salary reductions made?

When you become a Participant, your contributions will be taken out of your gross income via pre-tax salary reductions. These salary reductions must be made in substantially equal amounts throughout the Plan Year and not in lump sum payments or unequal payments throughout the Plan Year, unless there is an administrative error or other Plan provisions that justify an alternative method of unequal salary reductions.

Q-11. What effect will Plan participation have on Social Security and other benefits?

Participating in an IRC § 125 Reimbursement Plan may affect your future Social Security benefits. Plan participation reduces the amount of your taxable compensation. Accordingly, both you and Your Employer pay Social Security taxes on a lower amount of wages (assuming your income is below the taxable wage base). This could result in a decrease in your future Social Security benefits. Additionally, any other wage-based benefits (such as retirement, disability, or life insurance benefits) which are determined based on your taxable compensation may also be affected by participation in this Plan.

Q-12. What happens if a claim for benefits is denied?

If a claim for benefits as described in Part 6: Medical Reimbursement Benefits or Part 7: "Dependent Care Reimbursements" is denied, the Plan's Contractor for Administrative Services will notify you in writing within 30 days of the date you submitted your claim. This period may be extended by 15 days for special circumstances, including incomplete claim documentation. Such notification will explain the reasons your claim was denied and further advise you of what steps, if any, you might take to validate the claim. The Contractor for Administrative Services will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 180 days of the date of your request for a review. If you are denied participation in this Plan (such as the ability to defer a portion of your salary on a pre-tax basis) due to an issue relevant to your coverage under this Plan (such as a determination of a Status Change, other Permitted Election Change, or eligibility and participation matters

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under the Plan Document), the claims procedure outlined in Part 10: "ERISA Rights" will apply. The claim procedures for medical reimbursement claims fall under the "Post Service Claim" review rules as established by Department of Labor regulations.

Q-13. How does the Plan coordinate with the Family and Medical Leave Act?

In general, under the Family and Medical Leave Act of 1993 (FMLA), employers with 50 or more employees are required to offer eligible employees up to 12 weeks of unpaid leave during any 12-month period to care for themselves or family members during a serious health condition or for the birth or adoption of a child. FMLA requires employers to continue the group health coverage of an employee on approved FMLA leave and to restore benefits on return from that leave. For purposes of the FMLA, the Medical Reimbursement portion of this Plan qualifies as "group health coverage" and the FMLA therefore applies to this Flexible Benefits Plan.

If you take leave under the FMLA, you have two potential options regarding your election under the plan:

1) You may revoke your existing election under the Plan for the remaining portion of the Plan Year as described under Election Changes (Part 4) in this document.
2) You may elect to continue your participation throughout your FMLA Leave.

Your election of one of these two options must be made within 30 days of the start of your FMLA leave and you may not make or apply an election retroactively. If you do not make an election to the contrary as outlined under Part 4 of this document, your participation will be deemed to continue during your FMLA leave, coverage will continue during your leave, and premiums will be due as outlined in Q-14 below.

If you revoke your election and thus terminate participation under the Plan while on FMLA leave, claims incurred after the date of your FMLA leave will not be eligible and thus cannot be reimbursed. If you elect to revoke your election coincident with your FMLA leave, when you return to work, you may elect to reinstate your participation if you have experienced a qualified mid-year exception. The reinstatement must be made on the same terms as before the FMLA leave was taken and must be received within 30 days of returning from your leave. Participants on FMLA leave have the same rights to change benefit elections, such as a change in family status, as do other Participants.

Q-14. What are my re-payment options for missed salary reductions during FMLA?

If you choose to continue receiving Plan benefits while on FMLA, you are responsible for paying the same Salary Reduction amounts you were paying while not on leave. Several payment options are available to you while on FMLA leave:

1. Pre-pay basis - You may pre-pay your salary reductions before beginning unpaid FMLA leave. Payments under this option may be made on a pre-tax salary reduction basis from any available compensation. These payments will not be included in gross income, provided all Plan requirements are satisfied.

2. Pay-as-you-go basis - Under the pay-as-you-go option, you may make contributions to the Plan during paid or unpaid FMLA leave on the same schedule as if you were not on leave or you may make equivalent monthly contributions. If you are not receiving compensation during your leave, payments made under this option are made on an after-tax basis. If you are receiving compensation during your leave, such as salary continuation, sick leave, or vacation pay, your contributions may continue during your leave as pre-tax salary reductions.

3. Catch-up contributions - You may pay by making "catch-up" contributions after returning from your FMLA leave. Catch-up contributions may be made in a lump sum upon return from your FMLA leave or may be made by adjusting your ongoing Salary Reductions upon return from your FMLA leave to a new level basis to make up for any missed Salary Reductions during your leave. These contributions are typically made on a pre-tax basis. However, if necessary, after-tax contributions may also be made for catch-up contributions.

If your FMLA leave spans two Plan Years, you may not defer compensation from one Plan Year to a subsequent one. Therefore, you can only pre-pay Plan contributions on a pre-tax basis until the end of the Plan Year. You will be allowed to make up the amount missed while on leave in the next Plan Year but it must be on an after-tax basis.

Your rights under the Medical Reimbursement Plan remain the same as outlined above during the FMLA leave, assuming you elect to continue coverage under the Plan. In the case when the Participant elects to continue coverage during the FMLA leave, claims incurred during the leave may be considered eligible and reimbursements of these claims may be made. There will be no interruption in claims eligibility, regardless of the method of premium payment elected.

Reinstatement to the Medical Reimbursement Plan cannot be retroactive. As with other Plan benefits, you may elect to be reinstated in the Medical Reimbursement Account upon return from FMLA leave, as long as your request is received within 30 days of your return from leave. In this situation, you would maintain the same annual election that you had before the leave, although claims incurred during the FMLA leave period for which no salary reductions were made would not be eligible.

If "catch-up" contributions or unpaid "pay-as-you-go" contributions are due upon return from leave and the employee does not return to work, the catch-up contributions or unpaid pay-as-you-go contributions are due and payable. Your Employer reserves the right to take make-up salary reductions from any and all compensation payable to the employee, including vacation pay, sick leave or any salary continuation payments. If no compensation is available for salary reductions, the Participant must make direct payments to the Employer to re-pay the contributions due. Your Employer may consider unpaid contributions as any other debt owed to the Employer.

If a Participant returns to work after a leave and elects to pay catch-up contributions or unpaid pay-as-you-go contributions over the remainder of the Plan Year, but later terminates employment prior to when all catch-up contributions or unpaid pay-as-you-go contributions are made, the Employer reserves the same right to collect these unpaid contributions out of any available compensation or to collect the make-up contributions directly from the Participant as described above.

Q-15. How does the Plan coordinate with an unpaid leave of absence?

If you go on an unpaid leave of absence, the personnel policies of Your Employer will govern whether you may continue to participate in the Pre-Tax Flexible Benefits Plan. Typically, if you are eligible to continue participating in other employee benefit plans, you will also be eligible to continue participating in the Pre-Tax Flexible Benefits Plan. And typically, if you are not eligible to continue other employee benefit plans, you will not be eligible to continue participating in the Pre-Tax Flexible Benefits Plan. If your Employer's policies allow for continuation of participation while on unpaid leave, the same provisions apply as under an FMLA leave, as outlined above in Question 13 and Question 14. If your Employer's policies indicate that you may not continue, your participation in the Plan will be terminated. You will be offered COBRA continuation coverage under the standard provisions of the law if Your Employer is subject to Federal COBRA laws. Whether you can elect to make an election change at the time you go on an unpaid leave of absence is subject to all the election change provisions outlined in Part 4: Requirements for Changing Elections.

Q-16. What is federal COBRA Continuation Coverage and how does it work?

COBRA is a federal law that requires employers to offer continuation coverage to employees who lose health coverage in certain circumstances. Generally, the law applies to employers with more than 20 employees. COBRA Continuation Coverage means your right, or your spouse and dependents' right to continue coverage under any of the component health benefit Plans if coverage (for you, your spouse, or your dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- Termination of your employment (for a reason other than gross misconduct);
- Reduction of your work hours (which causes a loss of health coverage);
- Death;
- Divorce or legal separation from your spouse;
- Becoming entitled to receive Medicare benefits;

For a Qualifying Event, other than a change in your employment status, it is your responsibility to inform Your Employer in writing of the Qualifying Event within 60 days of the occurrence. After a Qualifying Event occurs you, your spouse, or your dependents (if covered) will receive a formal COBRA election notification as required by law. This notification will provide information about continuation rights and costs as well as the terms and conditions for continued coverage. Please note that a Medical Reimbursement Account is considered employee only coverage. Your dependents can not elect to continue this coverage under Federal COBRA.

COBRA Continuation Coverage under this Plan is only available with respect to Medical Reimbursement Accounts, and in most cases COBRA coverage under your Medical Reimbursement Account may only be continued through the end of the Plan Year in which the Qualifying Event occurred. If you elect to extend participation in the Medical Reimbursement Account through Federal COBRA, you will effectively extend your employment termination date for the purposes of determining when claims are considered eligible. Eligible claims incurred while you are continuing your coverage under COBRA are eligible for reimbursement. If you do not elect to extend your Medical Reimbursement Account through Federal COBRA for this Plan, medical reimbursement claims incurred after your employment termination date are not eligible. After the end of the Plan Year, you may not continue COBRA coverage under your Medical Reimbursement Account or re-elect coverage under a subsequent Plan Year.

Q-17. What modifications can my Employer make to my elections?

The Administrator may at any time require you to amend the amount of your Salary Reduction for a Plan Year if the Administrator determines it is necessary or advisable to satisfy any nondiscrimination requirements applicable to this Plan, to maintain the qualified status of benefits received under this Plan, or for any reason to satisfy the requirements of administering this Plan. Additionally, if during the Plan Year the cost of benefits provided under the Employee Benefits Plan provided by an independent third party whom you have selected changes, your benefit election shall automatically be adjusted to reflect such premium contribution change. You will not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided in Part 4: "Requirements for Changing Elections."

Q-18. How do the discrimination tests work?

The IRS rules require that the Plan be nondiscriminatory, which means it cannot provide benefits which favor Highly Compensated or Key Employees. Therefore, if necessary, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code). These generally include officers, shareholders and highly paid employees. If the Plan Administrator determines that the Plan does not satisfy the nondiscrimination requirements, benefit concentration tests or the benefit limitations of the Code, the Plan Administrator will take appropriate action to ensure compliance, including but not limited to modifying on a non-discriminatory basis, the elections of the highly compensated employees or key employees without their consent. If a benefit election is reduced or not allowed, it is treated as taxable compensation to the Employee. This action would be taken only to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

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Q-19. Will I have any administrative costs under the Plan?

Generally the Employer sponsors the majority of the cost of administering the Plan. In some instances, you may be required to pay a specific amount to participate in the Plan. Please note that this amount will be taken out of your reimbursement account election on a pre-tax basis. Please contact your benefits department for more information.

Q-20. How will I receive Plan Communication?

As a participant, you have three options by which you can receive your VitaFlex plan communication (e.g. Explanation of Benefits).

1. An e-mail containing a PDF copy of your VitaFlex plan communication.
2. Secure website access to your VitaFlex plan communication with e-mail notification for each new piece of communicated added.
3. VitaFlex plan communication sent via U.S. Mail.

Your Employer has chosen a Default Plan Communication Method and if you do not choose a method of communication, you will receive your communication via the default method. Please refer to Part I: "Important Plan Information" to identify the Default Plan Communication Method.

Please note that your Employer is charged for every piece of plan communication that is sent via **U.S. Mail.** Your Employer and the VitaFlex Team would like to encourage you to receive your plan communication using one of the electronic methods. You may change your communication method at any point in time during the Plan Year by contacting the Vita Service Center or your Employer.

Q.21. How long will the Plan remain in effect?

Your Employer expects to maintain the Plan indefinitely and has the right to amend, modify, or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-22. Are the provisions of this Plan a promise of employment?

None of the Plans or benefits of this Plan should be considered contracts for employment between you as the employee and Your Employer. This Plan does not guarantee any employee or Plan Participant the right of continued employment and is not an employment contract. Additionally, this Plan does not limit Your Employer's right to discharge any employee or Plan Participant.

Q-23. What happens if my employer goes out of business?

It is important to understand that the pre-tax salary reductions made from your compensation are held as a general asset of your Employer. Salary reductions are not set up in a separate trust that is protected from creditors. If you make contributions into your Medical Reimbursement account or Dependent Care Reimbursement account and if your Employer goes out of business, you may lose those contributions if you have not already received reimbursement for eligible expenses.

Q-24. Will I have to disclose private or protected health information?

It is important to understand that in order to receive reimbursement under this Plan, you must provide documentation of your medical and dependent care expenses to the Contractor for Administrative Services. Some of the required documentation may be private or protected health information. If you do not wish to disclose such information to Vita Administration Company as the Contractor for Administrative Services, your claims may not be eligible for reimbursement. You should carefully consider this requirement prior to electing to participate. (Also see Part 9: "Privacy.")

Q-25. What happens if I elect not to participate in this Plan?

Any portion of your compensation for which you do not choose to make a salary reduction and apply toward your Premium Contributions, your Medical Reimbursement Account or Dependent Care Reimbursement Account will be paid to you in full as regular, taxable compensation.

Q-26. What are Flex Credit Dollars?

Flex Credit Dollars are amounts that your Employer contributes on your behalf. You use your Flex Credit Dollars to pay for part or all of the benefits you elect. The amount of Flex Credit Dollars, if any, is determined annually by your Employer. Your Employer will communicate the Flex Credit Dollar allocation during Open Enrollment. Any Flex Dollar Credit may be adjusted upward or downward at your Employer's discretion. Details of Your Flex Credit Dollar allocation, including whether any cash out of unused Flex Dollar Credits is available, is found under Part 1: "Important Plan Information."

Q-27. What happens if I receive erroneous or excess reimbursements?

If it is determined that you have received payments under the Plan that exceed the amount of eligible expenses that have been properly substantiated during the Plan Year set forth in this document or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying dependent),

the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (1) the Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification. (2) The Plan Administrator may offset the excess reimbursement against any other eligible expenses submitted for reimbursement (in accordance with applicable law) or (3) withhold such amounts from your pay (to the extent permitted under applicable law). If the excess reimbursement could not be recouped, this could result in adverse income tax consequences for you.

PART 4: REQUIREMENTS FOR CHANGING ELECTIONS

Q-1. Can I change my election during the Plan Year?

Generally, you make an irrevocable election for the entire Plan Year and you may not change it during the Plan Year. You may always change your pre-tax elections in coordination with each new Plan Year. Except as outlined below, you may not change your election in any of the following ways during the Plan Year:

1. Your participation in this Plan,
2. Your Salary Reduction amounts, or
3. Your election of specific coverages under the Employee Benefit Plan

There are some specific exceptions to the irrevocability rule regarding when you can change your election during the Plan Year. Generally, you must experience a Status Change or other event that qualifies for a mid-year change of election. These are outlined in detail under Questions 3 and 4 below.

Q-2. What must I do to change my election?

You must request to revoke and/or change your election within 30 days of the qualified Status Change or other qualified exception that would allow you to change your election. Your request for change must be made in writing on a Mid-Year Exception/Status Change form. All changes must be prospective and may not be applied retroactively. If you do not request a change within 30 days of the qualifying event, your right to change your election is forfeited and you must wait until the next Annual Open Enrollment to make any election change.

Q-3. What is a "Status Change"?

If you experience a Status Change, you may revoke or change your election for remainder of the Plan Year. A Status Change is very strictly defined and must fall into one of the following categories:

1. Change in your legal marital status. This includes marriage, divorce, death of spouse, legal separation, and annulment.
2. Change in your number of tax dependents. This includes birth, adoption, placement for adoption, and death.
3. Change in your employment status. This encompasses any event that would change your employment status, your spouse's employment status, or your dependent's employment status, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, or a change in worksite. *The change in employment status must trigger benefit eligibility or ineligibility.*
4. Your dependent satisfies (or ceases to satisfy) dependent eligibility requirements. This includes attainment of maximum age under the employee benefit contract, gain or loss of student status, marriage, or any similar circumstance.
5. Adoption. This includes commencement or termination of adoption proceedings.

Any election change resulting from a Status Change requires that the revocation or new election must be consistent with the Status Change. To be considered consistent, a benefit election change must be both on account of and correspond to the Status Change. Additionally, in order to qualify as a Status Change, the change must affect coverage eligibility of the employee, spouse or dependent under an employer's Health Plan. If eligibility for benefits is not affected, then the change does not qualify as a Status Change.

Q-4. What are the other exceptions that allow me to make a Qualified Mid-Year Election Change?

There are several other exceptions to the irrevocability of election rules. In order to be eligible for a change in election, you must experience one of the following defined events:

1. Cost Change with Automatic Increase/Decrease in Contributions. If the Employee Benefit Plan you elect has a premium change, either mid-year or coinciding with the Plan Year, your Salary Reduction election may be automatically increased or decreased by the Administrator to cover your new required share of the premium. (This exception does not apply to Medical Reimbursement Accounts.)

2. Significant Change in Cost of Dependent Care. A Participant may revoke his/her benefit election and/or participation in the Dependent Care Reimbursement provisions of the Plan coverage during a Plan Year and, in lieu thereof, make a new Dependent Care Election for the remaining portion of the Plan Year. This assumes the revocation and new election are on account of a significant change in the cost of Dependent Care, and that the provider of care is not related to the Participant. All corresponding election and premium changes must be made on a prospective basis. (This exception does not apply to Medical Reimbursement Accounts.)

3. Significant Change in Cost or Coverage. If you experience a significant change in cost or coverage, you may revoke or change your benefit election and/or participation in the Employee Benefit Plan during a Plan Year for the remaining portion of the Plan Year, effective the latter of the following two dates. This assumes the revocation and new election are on account of a significant increase in the premium your original coverage or if such original coverage is significantly curtailed or ceases. (This exception does not apply to Medical Reimbursement Accounts.)

4. FMLA Leave. You may revoke or change your benefit election and/or participation in the Employee Benefit Plan coverage for the remaining portion of the Plan Year as may be provided for under FMLA. The new Election is effective as of the pay period following the date of FMLA leave.

5. HIPAA or CHIPRA Special Enrollment Rights. You may revoke and/or change your benefit election and/or participation in the Employee Benefit Plan coverage during a Plan Year for the remaining portion of the Plan Year if you experience any of the following types of events as required by HIPAA and CHIPRA (Children's Health Insurance Program Reauthorization Act). (This exception does not apply to Medical Reimbursement Accounts or Dependent Care Reimbursement Accounts. It applies only to the Premium portion of the Plan.)

   A. Special Enrollment for Loss of Coverage. The employee or dependent must have lost other group health Plan coverage because COBRA benefits are exhausted, because other non-COBRA group coverage terminated due to loss of eligibility for coverage, or because employer contributions for the non-COBRA group coverage were terminated.

   B. Special Enrollment for Acquisition of New Dependent. The employee must acquire a new dependent by birth, marriage, adoption, or placement for adoption. The special Open Enrollment right for a newly acquired dependent applies to the employee, the employee's spouse, and the newly acquired dependent.

   C. Termination of Medicaid or State CHIP (SCHIP) coverage resulting from loss of eligibility. The employee must request to change their election within 60 days of termination of Medicaid or SCHIP coverage. The election will be effective on the date that the corresponding health coverage begins. Please note that this Special Enrollment Right only allows an employee to enroll themselves or a qualified dependent.

   D. Becoming eligible for a premium assistance subsidy in the employer-provided group health plan under Medicaid or SCHIP. The election will be effective on the date that the corresponding health coverage begins. Please note that this Special Enrollment Right only allows an employee to enroll themselves or a qualified dependent.

6. Judgments, Decrees or Court Orders. You may revoke and/or change this benefit election and/or your participation in the Employee Benefit Plan coverage during a Plan Year for the remaining portion of the Plan Year pursuant to a judgment, decree, or court order resulting from divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order).

Q-5. What if I terminate employment and am later rehired?

If you terminate employment mid-year and are rehired within 30 days (or if you lose eligibility for the Plan due to an unpaid, non-FMLA leave), your participation is restricted to stepping back into your old election for the Plan Year. You are not required to make up any missed salary reductions, however any claims incurred while you were not an active employee will not be eligible.

If you terminate employment during the Plan Year and are rehired outside of 30 days, you will be treated as a new hire. You will be subject to the waiting period and will be required to make a new election for the period of time left in the Plan Year. For medical elections, claims must be incurred within the specific eligibility period for each separate election. The overall maximum amount that you can elect for a Medical Reimbursement Account (between multiple elections in the same Plan Year) will be determined based on your Employer's Plan design which is listed in Part I of this document. For the Dependent Care Reimbursement Account, you will not be allowed to elect more than the $5,000 IRS set maximum for the Plan Year. Please contact your benefits department or Vita Service Center for more detailed information.

PART 5: PREMIUM CONTRIBUTION BENEFITS

Q-1. What is the advantage of participating in the Premium Contribution portion of the Plan?

The premium contribution portion of the Plan allows you to pay the required contributions for the health insurance coverage that Your Employer makes available to you by reducing your compensation. This means that your contributions are made before federal income taxes, state income taxes and Social Security taxes are withheld. In other words, the Plan allows you to use tax-free dollars to pay for insurance coverage and premium expenses which you normally pay for with out-of-pocket, taxable dollars. The result is that you pay less tax and have more money to spend and save.

Q-2. How are Premium Contributions made?

Before each Plan Year begins, you will select the insurance coverage you desire. Then, during each pay period, contributions will be made automatically on your behalf as salary reductions from your compensation and used by Your Employer to pay the premium expense for the qualified group sponsored insurance coverage you have selected by Your

Employer. The premium contributions are NOT part of the Medical Reimbursement portion of this Plan, nor are group or individual premium contributions reimbursable under the Medical Reimbursement portion of this Plan. Required premium contributions are simply taken on a pre-tax basis, if so elected. You may change the premium election that you previously made each year at open enrollment. You may also choose not to participate in the Plan for the upcoming Plan Year. New elections must be made during the "election period" prior to the beginning of each Plan Year.

Q-3. Who is an eligible dependent?

Your eligible dependents include the dependents who qualify under the Insurance Contracts currently in force under the Employee Benefit Plan of your Employer and under Internal Revenue Code §152.

Q-4. What happens to my premium contribution election if I drop my insurance in the middle of the Plan Year?

The decision to elect to pay your insurance premiums pre-tax through the Plan is binding for the full Plan Year, unless you are eligible for a change allowed by the IRS, as described in Part 4: “Requirements for Changing Elections.” If you discontinue your insurance coverage in the middle of the Plan Year without an allowable reason (that is, Status Change or other qualified exception), you may be required to continue to have the premium salary reduction amounts deducted from your gross income under the Plan, even if coverage is discontinued.

Q-5. Can my employer modify my Premium Contribution election under the Plan?

If the amount of your required premium contributions(s) increases or decreases as a result of a rate adjustment required by an independent third party (such as an insurance company) or as a result of a change in the required contribution as determined by Your Employer, Your Employer will automatically increase or decrease the amount of your premium contribution election(s).

Q-6. Can I change my Premium Contribution election under the Plan?

Generally, you make an irrevocable election for the entire Plan Year and you may not change it during the Plan Year. You may always change your pre-tax premium election in coordination with each new Plan Year. There are some specific exceptions to the irrevocability rule regarding when you can change your election mid-year. These are outlined in detail in Part 4: “Requirements for Changing Elections.”

Q-7. Are COBRA premiums eligible salary reductions?

Yes, payment of COBRA premiums for group health coverage *sponsored by your Employer* is eligible for pre-tax salary reductions under the Plan. Such premium payments must be for COBRA coverage for an employee, spouse, or eligible dependents. Salary reductions *may not* be made to pay for COBRA coverage for a divorced spouse, a domestic partner, or any other person that is not an eligible dependent under the IRS tax code and your group health coverage Plan. Salary Reductions may not pay for any COBRA coverage other than coverage the group policy sponsored by your Employer. Additionally, salary reductions may not pay for coverage for a period of time outside of the Plan Year. COBRA premiums for coverage sponsored by any other employer are not eligible for pre-tax salary reduction under the Plan. Practically, COBRA premiums must be paid in advance of a termination event. Such a lump sum pre-payment of premiums is an acceptable exception to the requirement for substantially equal premium payments throughout the Plan Year. Although this is an eligible practice, your Employer reserves the right to not accommodate such a request.

Q-8. Are other individual health Plan premiums eligible salary reductions?

No, premiums for any health Plans that are not a group Plan directly sponsored by Your Employer are not eligible for pre-tax salary reduction under the Plan. This includes any individual health policy and any COBRA premiums for coverage through any other employer.

Q-9. Are HSA contributions eligible salary reductions?

If your Employer specifically supports the administration of HSA contribution salary reductions, they will be eligible salary reductions under an IRC §125 Plan. If you are currently enrolled in a qualified High Deductible Health Plan, you have the opportunity to make contributions to a Health Savings Account (HSA). In certain circumstances (based on Plan design), your Employer may allow you to reduce your salary and redirect these pre-tax monies into your personal HSA account. While HSA contributions are eligible salary reductions under the Plan, your employer is under no obligation to handle the administration of such salary reductions. You can make a change to your HSA contribution election on a prospective basis at any point in time during the Plan Year. Please refer to IRC § 223 for detailed eligibility rules and regulations.

PART 6: MEDICAL REIMBURSEMENT BENEFITS

Q-1. What is my "Medical Reimbursement Account"?

You have the opportunity to elect to receive income tax-free reimbursement for some or all of your qualified out of pocket medical expenses under the Medical Reimbursement Plan portion of the Plan. Under these provisions, you elect a specific level of salary deferrals and authorize Your Employer to make salary reductions, in lieu of receiving the corresponding

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amount of current pay. Your salary reductions are not taxable, and, therefore, you save Social Security and income taxes on the amount of salary reductions you elect.

If you elect to reduce your income under the Medical Reimbursement provisions of the Plan, a Medical Reimbursement Account (the Account) will be set up in your name to keep a record of the salary deferrals you have made during the Plan Year. The "Account" is maintained for accounting purposes only; there is not an actual monetary account set up in your name nor are there actual deposits in the Account. Interest is not accrued to your Account. Your salary reductions are accounted for, but the actual monetary salary deferrals are maintained as a general asset of your Employer. You may submit claims for reimbursements for up to the total amount elected in the Plan Year.

Q-2. What are the minimum/maximum amounts I can elect?

If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. You may elect to defer any amount of salary you desire, subject to the annual Plan minimum and maximum reimbursement limitations as specified under Part 1: "Important Plan Information."

Q-3. What does "Use It or Lose It" Mean?

The most important Plan restriction is the "use it or lose it" rule. You must carefully estimate your annual medical expenses <u>prior</u> to your election. If you over-estimate your expenses and do not actually incur your estimated eligible medical expenses by the Claims Incurred Deadline, your unused salary reduction contributions will be forfeited at the end of the Plan Year.

Q-4. What is the Claims Incurred Deadline?

The Claims Incurred Deadline is the last day of the Plan Year. Please refer to Part I: "Important Plan Information" for your specific Claims Incurred Deadline. You should always try to incur expenses equal to your election *during* the Plan Year and prior to the last day of the Plan Year. However, in some cases, your Employer may make an election to extend the Claims Incurred Deadline to allow for claims to be incurred up to 2½ months after the end of the Plan Year so that salary reductions that might otherwise be forfeited might be eligible for reimbursement. This provision is commonly referred to as the Grace Period.

There are many complex reasons (both administrative and financial) why your Employer may or may not elect to extend the Claims Incurred Deadline. It is important to understand that it may only be elected in advance on a Plan-wide basis and exceptions cannot be made for a specific participant. Please check the Claims Incurred Deadline in Part 1: Important Plan Information of this document to confirm whether or not the Grace Period applies and for the last date to incur claims under this Plan.

How does the Grace Period Work?

It is important to note that if your Employer has adopted the Grace Period and the Claims Incurred Deadline is extended to allow claims to be incurred during the 2½ months following the Plan Year (refer to Part 1: "Important Plan Information"), you must be aware that all claims will be adjudicated *in the order they are received* (with full documentation). Additionally, claims will be applied to any balance in the prior Plan Year until that balance is exhausted; then, claims will be applied to any election in the current Plan Year. In certain circumstances, this may cause a problem that you must be aware of and that you may need to manage carefully in order to avoid losses. In short, the order in which claims are submitted can have a significant (and potentially negatively) impact on whether and how claims submitted during the grace period are reimbursed. The following example illustrates this potential situation:

<u>Prior Plan Year</u>

January 1st	Elect $1,000
As of November 29th	Reimbursed $850
November 30th	Incur hospital claim for $250 (but hospital doesn't process claim right away)
December 31st	End Plan Year with balance of $150

<u>Current Plan Year</u>

January 1st	Elect $1,000 for new Plan Year
January 15th	Incur $200 vision care expense and submit claim
January 16th	Claim is processed. $150 is applied to the remaining prior year's balance and $50 is applied to current year's election. Prior year's balance is now $0. Current year's balance is now $950.
January 17th	Prior year $250 hospital claim paperwork is processed and you submit the claim.
January 18th	The $250 hospital claim is denied. The $250 hospital claim will never be applied to *either* the prior Plan Year or the current Plan Year. The account balance for the prior Plan Year was $0 at the time the claim was submitted, therefore, no reimbursement could be made. Additionally, the claim is not eligible for the current Plan Year (since it was incurred in the Prior Plan Year). Had there been a balance left in the prior Plan Year, the $250 hospital expense would have been eligible, however the prior year's balance was used up by the vision care expense from the current Plan Year. If the current Plan Year election of $1,000 was to have included the $200

vision care expense, you may have a shortage in your incurred expenses for the current Plan Year and thus may be subject to a potential loss.

Q-5. Whose expenses are eligible?

You, as the Participant, your spouse, and any of your qualified dependents can incur expenses on your behalf. These expenses need to be submitted by you as the participant. Dependents are defined under the Medical Reimbursement Account as any individual who is a dependent of the Participant within the purview of Internal Revenue Code §152.

Qualified expenses for you and/or your eligible dependents are eligible for reimbursement *regardless* of whether you have waived off of the group sponsored health plan coverage offered by Your Employer. You do not need to elect to be covered under Your Employer's health plans in order to participate in this Plan. If you and/or your dependents are covered by a spouse's plan, another employer sponsored plan, or an individual plan, you and your dependents qualified, otherwise un-reimbursed expenses are eligible for reimbursement under this Plan.

The IRS will treat certain children whose parents are divorced, separated, or living apart as dependents of both partens for purposes of employer-provided accident and health coverage, deductible medical expenses, qualified medical expenses under HSAs, regardless of whether the custodial parent releases the claim to exemption.

Q-6. How is my Account maintained?

When you complete the election form (online or paper), you specify the amount of medical reimbursement you wish to elect for the Plan Year. During the Plan Year, contributions to your medical reimbursement account are set up as salary reductions from your gross income each paycheck and credited to your medical reimbursement account. (Your per-paycheck contribution is calculated by dividing the total annual amount elected by the number of remaining paychecks in the Plan Year, so your salary reductions are equal throughout the Plan Year.) The full amount of the coverage elected will be available for reimbursement for your eligible medical expenses at any time during the Plan Year, so long as you continue your salary deferrals and participate in the Plan. Payments are from general Employer assets. For example, suppose you have elected to be reimbursed for up to $1,200 per year for medical expenses. Your Account would be credited with a total of $1,200 at the beginning of the Plan Year. If you are paid twice per month, you would contribute $50.00 per pay period into your Account throughout the Plan Year for the benefit that you have elected.

Q-7. Can I request reimbursement at any time during the Plan Year?

Provided you continue to make your periodic contributions through your salary reductions, the full annual amount of coverage elected will be available at any time during the Plan Year. Your balance will be reduced by the amount of prior reimbursements received during the Plan Year.

Q-8. How do I receive reimbursements?

If you elect to participate in this Plan, you must take certain steps to be reimbursed for your eligible medical expenses. When you incur an expense that is eligible for reimbursement, you must submit a claim to the Plan Administrator on the Claim Form provided. All claims must include a signed Claim Form along with full and complete documentation of the expense incurred. Requirements for necessary documentation are outlined in Question 15 of this section.

Provided you have commenced salary reductions, you will be reimbursed for your eligible medical expenses as soon as administratively feasible. The specific method by which you will receive your reimbursement is identified in Part 1: "Important Plan Information". Details of this reimbursement method are outlined in Part 8: "Reimbursement Methods". The specific claim reimbursement process is outlined in the welcome letter you receive with your claim kit after you formally elect. To have your claims processed as soon as possible, please read and follow the directions provided in the Claim Kit, which is mailed to your home after your election or sent electronically through e-mail.

Q-9. When must the Eligible Medical Expenses be incurred?

Eligible Medical Expenses should be *incurred during* the Plan Year that you have elected to participate in the Plan. The deadline for incurring Eligible Medical Expenses is identified as the Claims Incurred Deadline in Part 1: "Important Plan Information".

Additionally, eligible expenses must be incurred after your initial eligibility date if you are a new hire and after you have signed the election form. Expenses incurred prior to the beginning of the Plan Year, prior to your initial effective date, prior to the date that you signed the election form, or after the end of the Plan Year are not eligible. To 'incur' an expense means the date when the Participant or dependent is provided with the care that gives rise to the expense, not when the Participant or dependent is formally billed/charged or actually pays for the care.

If your employment terminates, you may be reimbursed only for expenses incurred on, or prior to, your termination date. If you elect to continue your Medical Reimbursement Account under COBRA, the eligibility date for incurring expenses may be extended to the end of the Plan Year. If you do not elect to continue your coverage under COBRA, you may not be reimbursed for any expenses incurred after your date of employment termination.

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Q-10. What is the deadline for submitting claims?

You will have until the Claims Submission Deadline identified in Part 1: "Important Plan Information" to submit claims for eligible medical expenses incurred during the previous Plan Year. All claims must be submitted by the Claims Submission Deadline to be considered for reimbursement. Claims received after the Claims Submission Deadline are not eligible for reimbursement. Additionally, any claims received prior to the Claims Submission Deadline without complete documentation and/or where complete documentation is not submitted by the Claims Submission Deadline are not eligible for reimbursement regardless of whether or not you are active or terminated.

If the Plan is terminated or there is a change in Contractor for Administrative Services prior to the end of the Plan Year for any reason, participants must submit any claims incurred prior to the termination date or date of change in Contractor for Administrative Services along with complete documentation by the date specified at the time of termination. If Your Employer goes out of business, claim submission deadlines may be significantly shortened and you may not be able to receive any reimbursement, despite having made contributions to your account.

Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" generally means any medical, dental, or vision expense which you could have claimed a medical expense deduction on an itemized, federal income tax return (without regard to any threshold limitation) AND which is eligible under the terms and conditions of this Plan. In addition, the expense must not otherwise have been reimbursed from any insurance Plan. In order to be considered eligible, the service or supply must be medically necessary, that is, utilized for medical reasons only, not for general health reasons. For example, physical therapy for general well being or cosmetic services would not be considered eligible expenses. Non-prescription drugs available "Over-The-Counter (OTC)" that are used to treat an illness or injury are eligible when purchased in reasonable quantities.

Following is a partial list of common health care expenses that are generally eligible for reimbursement from your Medical Reimbursement Account. This list should serve as a reference only. It is not a complete list of eligible expenses, nor is it an itemized approved list of expenses by the Internal Revenue Service (IRS), as determinations are made by the IRS and may vary from year to year. While this list is not exhaustive, it provides an overview of the type of expenses that may be eligible under the VitaFlex Plan.

Medical Services
- Ambulance Expenses
- Birth Control Pills
- Christian Science Fees
- Coinsurance
- Copayments
- Deductibles
- Hospital Expenses
- Immunizations and Vaccinations
- Laboratory/X-ray Fees
- Physician Fees
- Rx Drug Co-payments
- Routine Physical Exams
- Sterilization Expenses
- Surgical Expenses
- UCR Excess Charges

Other Services
- Childbirth Classes
- Fertility Treatments
- Sales Tax on Medical Items

Dental Services
- Dental Care
- Dentures
- Orthodontia (only treatment incurred during Plan Year)
- Dental Exams
- Occlusal Guards
- Implants

Vision Services
- Corrective Contact Lenses
- Eye Exams
- Eyeglasses (corrective)
- Laser Eye Surgery
- Prescription Sunglasses

Durable Medical Equipment
- Blood Pressure Monitoring Device
- Crutches
- Hearing Aids
- Oxygen
- Wheelchair

Therapy*
- Acupuncture
- Chiropractic Care
- Counseling Services
- Drug/Alcoholism Treatment
- Massage Therapy
- Physical Therapy
- Psychiatry
- Psychologist Fees
- Speech Therapy

Over-the-Counter Items
- Allergy Medication
- Antacids
- Bandage Materials
- Canker & Cold Sore Relief
- Cold & Sinus Medication
- Contact Lens Solution
- Contraceptive Devices
- Pain Relievers
- Wound Ointment
- Smoking Cessation Products

** These expenses require confirmation of medical diagnosis and a statement of the medical necessity of the specific treatment.*

If you have questions on eligible expenses, please contact Vita for assistance in seeking clarification prior to making an election to participate. If you plan on having an expense reimbursed and you later find out that it is not eligible, you may not change your election. *The best resource for claim eligibility is the searchable database on the VitaFlex website at* www.vitaflex.net. For additional information regarding questions on eligibility of certain expenses contact Vita at 650-966-1492 or at 800-424-3052 or via e-mail at **flex@vitamail.com**.

You may also consult your personal tax advisor, IRS Publication 17 "Your Federal Income Tax" or IRS Publication 502, "Medical and Dental Expenses", which identifies general principles for eligibility of medical expenses for tax deduction purposes. However, please note there are certain items that may be eligible for personal tax deduction and thus listed in Publication 502 and otherwise generally accepted as eligible expenses for a personal tax return that are NOT eligible expenses under the VitaFlex Plan. In some cases, guidance from the IRS on expense eligible is vague or difficult to administer. In these circumstances, Vita has developed detailed policies on the eligibility of expenses so that they can be applied uniformly to all plan participants. The VitaFlex policies and procedures take into account available guidance from the

IRS, but in some cases this Plan is more restrictive as to eligibility of expenses what might be eligible for reimbursement under a personal tax return.

Vita retains full authority to make final determinations as to whether or not a claim is considered eligible for reimbursement under the guidelines of the Plan. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided. Please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 502 or by other IRS guidance) that are specifically and purposefully excluded from this Plan due to the difficulty associated with documenting and administering reimbursement for these items.

In any circumstance where there is disagreement between the IRS guidelines (the IRS Code, IRS regulations, or phone advice provided by an IRS customer service representative) and the Plan Document and administrative policies of Vita will prevail as the governing practice.

It is also important to note that IRC Section 125 and Publication 502 have different rules on when an expense must be incurred. To 'incur' a health care expense, as defined by Section 125, means the date when the Participant is provided with the care that gives rise to the health care expense, not when the Participant is formally billed/charged or actually pays for the care. In some circumstances, the rules regarding when an expense is considered to be incurred are different for personal tax deductions. You may order a current copy of IRS Publication 502 by calling the IRS at 800-829-3676 or by visiting www.irs.gov.

Q-12. Special Information on Certain Expenses

Certain claims including but not limited to counseling, psychotherapy, physical therapy, and orthodontia require special consideration and are only eligible in certain circumstances. Following is an outline of the details of some of these types of medical expenses.

Counseling or Psycho-therapy	Only expenses for counseling and psychotherapy that are "medically necessary" for the treatment of an illness are eligible. The IRS guidelines indicate that in no circumstance is relationship counseling of any kind considered eligible. Therefore, marriage counseling, family counseling, or counseling for personal growth are not eligible expenses. VitaFlex Plan guidelines require confirmation of medical necessity prior to reimbursing any counseling or psychotherapy claim.
Physical Therapy	Only expenses for physical therapy which are "medically necessary" for the treatment of an illness or injury are eligible. A physical therapy claim must be accompanied by a medical diagnosis and must be for the treatment of an injury or illness or for the immediate alleviation of pain.
Massage Therapy	Only in very limited circumstance is massage therapy an eligible expense. Only expenses for massage therapy which are expressly deemed "medically necessary" for the treatment of an illness or injury are eligible. A massage therapy claim must be accompanied by a medical diagnosis and must be for the treatment of an injury or illness or for the immediate alleviation of pain. Therapeutic massage purely for general stress reduction or general well-being is not considered eligible. Massages given at a day spa will not be eligible.
Orthodontia Treatment	All orthodontia claims must be pro-rated over the entire course of treatment to determine when they are "incurred". Only expenses that are "incurred" *during* the Plan Year are considered eligible. For example, if a person starts 18 months of orthodontia treatment in January that is projected to cost $1,800, then the pro-rated cost would be $100 per month. In this example, only the $1,200 of orthodontia expenses that were actually "incurred" during the Plan Year could be reimbursed during that Plan Year. Proof of payment is required before any orthodontia reimbursements can be approved. Vita requires that all orthodontia claims require a Treatment Plan prepared by the orthodontist. A Treatment Plan must confirm the following items: treatment start date, expected completion date, charges for services, insurance benefit information and any up front fees. Please note that a Treatment Plan is different than a Financial Agreement with your orthodontist. Often you will receive a Financial Agreement or financial payment plan from your orthodontist, however, such documentation will not be sufficient if it does not outline the starting date of treatment and the expected duration of treatment, not just the duration of the payment plan. This is important because the financial payment schedule is not always the same as the treatment schedule.
Prescription Drugs	Prescription drugs are considered incurred on the date the drugs are dispensed at the pharmacy, not on the date they are picked up and/or paid for.
Transportation Fees	Transportation Fees, including, but not limited to parking fees, gas, mileage, airfare and lodging, are not eligible expenses for reimbursement under this Plan. (Please note, although in certain limited circumstances, some transportation expenses may be eligible for personal tax deduction under the IRS code Section 213, however such expenses are expressly not eligible under this plan.)
Gym Membership Fees	Gym or fitness club membership fees are not considered eligible for reimbursement under any circumstance, even if prescribed to treat a specific condition. However fees paid to a personal fitness trainer to treat a specific medical condition will be reimbursable if a physician has indicated that these services are medically necessary to treat the specific medical condition.
Weight Loss	Only expenses for a weight loss program which are prescribed by a physician to treat an existing

Programs — medical condition would be reimbursable. A diagnosis code would need to be present in order to denote medical necessity. Ancillary expenses for the program, such as food, are not eligible.

Food Expenses — Food expenses of any kind are not eligible expenses for reimbursement under this Plan. This includes medically necessary food items and/or special foods that are required as part of a special diet of any kind, regardless of whether the special food item or food plan is prescribed by a physician as part of a treatment for a medical condition. (Please note, although in certain limited circumstances, some food items may be eligible for personal tax deduction under the IRS code Section 213, however such expenses are expressly not eligible under this Plan.)

Q-13. Which Medical Expenses are Not Eligible?

The IRS has provided specific guidelines for expenses that may not be reimbursed on a pre-tax basis. Certain healthcare expenses are not considered qualified and thus are not eligible for reimbursement, *even if they are prescribed by a physician.* Medical expenses are not eligible if they are not directly for medical purposes or not deemed medically necessary. All eligible expenses require a medical diagnosis and must not be for cosmetic purposes. Following is a partial listing of common medical expenses that are not eligible for reimbursement. This list is not exhaustive, but provides an overview of the type of expenses that are ***not*** eligible under the VitaFlex Plan.

Over-the-Counter Items
- Anti-Aging Products
- Beauty Products
- Bottled Water
- Cosmetics
- Dental Floss
- Diapers
- Food (any type for any reason)
- Herbal Supplements
- Sexual Enhancers
- Toiletries
- Toothpaste or Toothbrush
- Vitamins
- Any OTC Products used for general health or well-being
- Any OTC Products purchased in stockpile quantities

Personal Care/Well Being
- Childrearing classes or services
- Counseling for Relationship or Personal Growth
- Custodial Care
- Domestic Help Expenses
- Food Expenses (even if part of a weight loss program)
- Health Club Memberships/Dues
- Massage Therapy for general health or relaxation
- Nursing Care for home care of healthy newborn
- Physical Therapy w/o medical diagnosis
- Psychotherapy for Relationship or Personal Growth
- Social Activities or Programs
- Stress Management Classes/Therapy

Dental Services
- Cosmetic Dentistry
- Orthodontia (any treatment incurred outside the Plan Year)

Other Services
- Funeral or Burial Expenses
- Health Insurance Premiums
- Home or Automobile Insurance
- Long Term Care Expenses
- Long Term Care Premiums
- Marijuana or Other Illegal Substances
- Maternity Clothes
- Parking Fees
- Transportation Expenses
- Weight Loss Programs
- Long Term Embryo or Sperm storage

Please note your premium contributions for your Employer sponsored employee benefit plans may be paid on a pre-tax basis under the Premium Contribution Benefits section of this Plan, as outlined in Part 5: "Premium Contribution Benefits". Premium contributions are not eligible for reimbursement under the Medical Reimbursement portion of this Plan. Additionally other individual or COBRA health Plan premiums are never eligible under the Medical Reimbursement portion of the Plan.

Certain expenses may be considered eligible under the IRS code (for a tax deduction on your personal income tax returns outlined in IRS Publication 502), but are not eligible under this Plan. This is typically due to documentation requirements that are outside the scope of Plan administration. Such expenses include, but are not limited to, transportation costs, mileage reimbursement expenses, and food of any type.

There are many expenses that may not be listed on either of the lists of eligible or not eligible expenses. For a more detailed information regarding eligible expenses, ineligible expenses, and documentation requirements, please visit the VitaFlex website at **www.vitaflex.net** or contact VitaFlex at (650) 966-1492 or **flex@vitamail.com**. If you have questions about whether a medical expense is eligible, please seek clarification prior to making an election to participate. If you submit an expense and you later find out that it is not eligible, you may not change your election.

Q-14. What are the Guidelines for Over-the-Counter Medications?

In an effort to provide clarity regarding how over-the-counter item expenses will be treated, VitaFlex has identified five categories of over-the-counter items and has provided a description of how each will be treated and what documentation is required for each.

All over-the-counter expenses are also subject to an IRS rule against stockpiling. This means you may not purchase over-the-counter medicines or products in "stockpile" quantities. This generally means quantities that you will not be able to consume within the Plan Year. A product is considered "consumed" if the packaging is opened. Without a doubt, the day-to-day application of the IRS rules against stockpiling can be difficult to understand. Once again, the general rule would be to confirm that the items would be consumed within the Plan Year. If you have questions regarding whether a certain amount of an over-the-counter item would be considered stockpiling, please contact Vita.

Following is an overview of the five categories of over-the-counter expenses, the eligibility specifications of each type, and the documentation requirements necessary for certain types of over-the-counter expenses.

1. Products with a Drug Compound – Presumed Eligible

   Any product with a drug compound that is governed by the FDA and that is specifically designed for a medical purpose is presumed to be an eligible OTC medication. Examples of such products include:
   - Pain Relief Medications: Advil, Tylenol, Aleve, Aspirin
   - Cold/Flu Remedies: Theraflu, Robitussin, Tylenol Cold, Dimetapp, Benadryl, Claritin, Sudafed, cough suppressants
   - Digestive System Medications: Pepto-Bismol, Imodium, Zantax, laxatives
   - Skin/Foot Medications: Cortisone Cream, Wart Remover, Lamisil, Anti-Fungal Cream
   - First Aid Products: Neosporin, Antibiotic Cream, Benadryl Anti-Itch

2. Products without a Drug Compound with a Single Presumed-Medical Use **–** *Eligible on a Product Specific Basis*

   There are many products with medical applications that do not include a drug compound (and thus are not governed by the FDA) and therefore cannot be immediately presumed to be used for medical purposes. However, if the product is generally utilized only for a single purpose which is medical in nature, the Over-the-Counter product may be approved as an eligible expense. If the product may potentially have a dual purpose, it cannot be approved under this category. Examples of such products include:
   - Wound Treatment: Band-Aids, Gauze Pads, Ace Bandages
   - Cold Remedies: Vicks Vapo-rub, Cough Drops
   - First Aid Products: Rubbing Alcohol, Hydrogen Peroxide
   - Injury Treatment: Cold Packs, Joint Brace (Ankle, Knee, Finger, etc.)
   - Children's Illness Treatments: Diaper Rash Ointment
   - Denture Care: Denture Adhesive
   - Contact Lens Cleaning: Bausch & Lomb Contact Lens Solution
   - Diabetes Supplies: Test strips, Lancets and Tips, Glucose Monitors
   - Health Monitors: Blood Pressure Monitor, Cholesterol Monitor
   - Fertility Products: Ovulation Predictor Kits, Pregnancy Tests

3. Dual Purpose Items – *Require Additional Documentation and a Physician Note of Medical Necessity*

   There are many products that may be used for medical purposes but also may potentially be used for non-medical purposes. Generally, these products are not eligible without additional documentation from a medical provider stating the medical necessity of utilizing the specific product for a medical purpose. While we understand this may be a "hassle" for plan participants, it is necessary to confirm the medical necessary of the product usage in order to authorize it as eligible. Without a specific medical confirmation for a dual purpose Over-the-Counter product, the item will not be an eligible expense. Examples of such products include:
   - Certain Lotions: Sarna Lotion
   - Certain Allergy Products: Air Purifier
   - Certain Acne Treatments: Retin-A, Differin
   - Breast Pump Supplies: Rental Fees, Supplies
   - Herbal Treatments: St. John's Wort, Cranberry Supplements, Garlic Pills, Ginkgo Bilboa
   - Medicated Shampoo: RID, Other Medicated Shampoos
   - Certain Vitamins: Pre-natal Vitamins, Other vitamins to treat medical conditions

4. Marginal Cost Items – *Require Additional Documentation and Physician Note of Medical Necessity*

   Certain dual purpose items are typically utilized in the daily life of most persons as a personal care item. With certain personal care items, a medical condition may give rise to an additional cost in the purchase of the standard item. In these circumstances, the *marginal additional cost* attributable to the medically required product versus products available to the general public for every day use may be an eligible expense. Examples of this include orthopedic shoes, allergy-sensitive bedding products, Braille books and magazines.

   How this marginal cost is calculated is important to understand. The general public uses certain products as a personal care items. Such products can range in price dramatically depending on the quality and where the product is purchased. Both an average quality product and a high-quality (more expensive product) may be available to the general public. In this circumstance, the marginal cost will be calculated based on the difference between the higher cost product and the medically necessary product, not difference between the average cost product and the medically necessary product. This is necessary since we are not able to make assumptions that any particular plan participant would have purchased the average cost product. In many cases this methodology eliminates or significantly reduces the marginal cost which may be an eligible expense. For any such items, Vita will determine the marginal cost based on web searches for the personal care item. Following is an example which illustrates this type of expense:

Allergy Sensitive Mattress Pad		$200
Cost for a Basic Mattress Pad	$100	
Cost for a Deluxe Mattress Pad	$180	

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Average Cost of a Mattress Pad	$140
Eligible FSA Expense	$ 60

The eligible FSA expense is the difference between the average cost of a non-medically necessary mattress pad and the actual amount paid for the mattress pad which was specific for the medical condition, which in this case is $60.

5. Personal Care/General Well-Being/Cosmetic Products – *Not Eligible*

   Products that are generally used for personal care, for general well-being, or for the promotion of health are not considered eligible expenses. Examples of such products include:

   - Personal Care Products: Toothpaste, Efferdent, Chapstick, Shampoo, Conditioner
   - Personal Hygiene Products: Shaving Cream, Razors, Q-Tips, soap, sunscreen, etc.
   - Vitamins: Centrum, Geritol, Iron Supplements, Calcium Supplements
   - Diet Enhancers: Appetite Suppressants, Diet Pills
   - Food Products: Slimfast, Balance Bars, Body Building Products, Weight Watchers, Diet Food, etc.
   - Beauty Treatments: Face Creams, Makeup (Medicated or Otherwise), Nail Polish, Tanning Salons
   - Hair Treatments: Nair, Permanent Waves, Hair Coloring
   - Dental Treatments: Teeth Whitening Products
   - Clothing: Maternity clothes, Other special clothing products

   If you have questions about the category or general eligibility of over-the-counter expenses, please contact Vita at (650) 966-1492 or flex@vitamail.com.

Q-15. What documentation is required for a claim?

The IRS specifically requires third-party substantiation to document all eligible expenses. Expenses that do not have complete documentation cannot be reimbursed. Do not include any expenses that cannot be appropriately documented in your estimated reimbursement calculation for the year, as they cannot be reimbursed.

For medical expense claims, appropriate documentation would include an insurance company Explanation of Benefits (EOB) statement, medical supply bills, co-payment receipts, provider billing or any other documentation from an independent third party which confirms that the expenses were incurred and identifies the elements necessary for a claim. The necessary elements for a valid claim include the following: patient's name, provider's name, dates of service, a description of service, the amount charged for the expense, and the amount, if any, covered by insurance.

For prescription expenses, a copy of the Rx receipt provided by the pharmacy is required. A cash register receipt or credit card receipt is not sufficient. For contact lens solution, a copy of the cash register receipt that identifies the product purchased is necessary. For over-the-counter drugs and medicines, a copy of a cash register or similar receipt that itemizes the individual product and associated expense will be required.

Reimbursement of certain medical expenses (such as psychotherapy and physical therapy) also requires confirmation of medical diagnosis code or a statement of the medical necessity of the treatment by the provider.

All orthodontia claims require a Treatment Plan prepared by the orthodontist which outlines the treatment start date, expected completion date, charges for services, insurance benefit information and any up front fees. Please see Question 12 for important distinctions between a treatment plan and a financial/payment plan. For more information on orthodontia claims, please visit the VitaFlex website at **www.vitaflex.net** and read the VitaFlex "Orthodontia Reimbursement Guidelines".

When medical necessity must be confirmed, claims must be accompanied by additional documentation. Additionally, anytime a provider billing statement or other non-EOB documentation is utilized, a copy of the EOB from the medical or dental insurance carrier(s) must also be provided, unless specific insurance reimbursement information is discernable from the detailed billing statement. This is required in order to confirm the portion of the claim that has already been reimbursed (or denied reimbursement) by any insurance plan.

Copies of cancelled checks, credit card receipts, cash register receipts (except for contact lens solution and OTC drugs and medicines), or any receipt without complete documentation outlined above alone are not considered sufficient documentation. Additionally, balance forward billing statements that do not outline the services provided and specific dates of service are also considered insufficient documentation.

Vita Administration Company has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita Administration Company retains full authority to confirm whether a claim is deemed eligible according to the IRS and the Plan and whether appropriate documentation has been provided. Final authority to accept or deny a claim based on sufficiency of the documentation provided rests with Vita Administration Company.

Q-16. What if the medical expenses I incur are less than the amount I have elected?

Any unused amount in your Account will be forfeited. You will not be entitled to receive any direct or indirect payment of any difference between the actual medical expenses you have incurred and the annual coverage you have elected and/or the total amount of your actual salary reductions. Any unreimbursed balance in your Account will be forfeited and restored to

Your Employer if a sufficiently documented claim for Eligible Medical Expenses has not been submitted by the claims submission deadline of the Plan Year for which the election was effective. Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

Q-17. What if I am currently participating in an HSA plan?

In general, if you are currently participating in a qualifying medical plan and are either making contributions to a Health Savings Account (HSA) or having contributions made to a Health Savings Account on your behalf, then participation in the Medical Reimbursement component of this Plan will disqualify you from making contributions to your HSA plan. However, you may make an election to change your Medical Reimbursement Account into a Limited Purpose Medical Reimbursement Account. A Limited Purpose Medical Reimbursement Account restricts eligibility to those expenses that will not disqualify you from making contributions under your HSA. This means that regular medical expenses will not be eligible for reimbursement until after your individual or family high deductible has been met. Only dental expenses, orthodontic expenses, vision expenses, medical expenses that are preventive in nature, medical expenses that are incurred after you have satisfied the statutory minimum annual deductible (post-deductible medical expenses) as set forth by IRC § 223, are eligible for reimbursement under a designated Limited Purpose Account. Please note for post-deductible expenses, you must submit documentation that your deductible has been satisfied prior to any such expenses being eligible for reimbursement. For more information, please reference the VitaFlex website at **www.vitaflex.net**.

Please note that any contribution into an HSA account may be restricted based on whether your Employer has elected the Grace Period provision and thus extended your Claims Incurred Deadline of this plan. If the Claims Incurred Deadline crosses a Plan Year, then your eligibility to contribute to an HSA account may be limited. Please consult your tax advisor for additional information.

Q-18. How do I elect a Limited Purpose Account?

You may elect to have this Plan treated as a Limited Purpose Medical Reimbursement Account, wherein only dental expenses, vision expenses, over-the-counter items, and post-deductible medical expenses will be eligible for reimbursement. You must make an affirmative election for the Limited Purpose Medical Reimbursement Account. This election may be made via a formal election or by notifying VitaFlex of your participation in an HSA plan and of your desire to make a Limited Purpose Account election. This notification will invoke self-imposed restrictions in this Plan which limits eligible expenses to only those defined under a Limited Purpose Medical Reimbursement Account. Vita Administration Company is not responsible for reimbursements made under the Medical Reimbursement Account that would otherwise disqualify the Plan participant under an HSA plan for a period of time prior to the election of a Limited Purpose Medical Reimbursement Account or if an erroneous notification was made. The election into a Limited Purpose Medical Reimbursement Account is made at a participant level and is voluntary. The election must be made prospectively (prior to claim submissions) on an annual basis, for the entire Plan Year.

If you are contributing to an HSA plan and you submit medical expenses and do not notify Vita of your election of a Limited Purpose Account, the reimbursements could disqualify your HSA. It is not the responsibility of Vita to know whether or not you are contributing to an HSA account and thus are not eligible to submit claims under the Plan without disqualifying yourself. Regardless of whether contributions to your HSA account are yours or are made on your behalf through your Employer, you are responsible for notifying Vita if you wish to elect under the Limited Account provisions of this Plan.

Q-19. How do Employer matching contributions work?

Your Employer may elect to provide a seed contribution or to match your annual elections. Any such seed contribution or matching contribution is entirely discretionary and is subject to change annually at the beginning of each Plan Year. Any such Employer seed or matching contribution will be applied on a non-discriminatory basis. If such an additional Employer contribution is provided, the entire amount of the seed or matching contribution is available for reimbursement at the time you make your election. However, if you do not incur expenses during the Plan Year that exceed your combined salary reductions and your Employer's seed or matching contributions, your salary reductions are utilized first and the employer match is utilized second for reimbursement purposes.

The amount of Employer match, if any, is indicated in Part 1: "Important Plan Information" of this document. The maximum election indicated in Part 1 reflects your annual election (the amount of your personal salary reductions), not the combined potential account value if your employer provides a seed or matched contribution.

Q-20. What is a "Qualified Reservist Distribution (or "QRD)"?

H.R. 6081 or the "Heroes Earnings Assistance and Relief Tax Act of 2008 (or "HEART" Act) allows reservists (as defined by 37 U.S.C. § 101) to receive all or a portion of their Health FSA account balance if they are called to active duty for 180 days or more. This distribution may be made any time from the date of the call of duty through the last day of the claims submitted deadline for the Plan Year in which the call occurred. The taxable distribution will be equal to the amount reduced from the participant's salary less any reimbursement amounts. The request for the distribution must come in the form of a written request within 60 days of the active call to duty date. Please contact your Employer's Human Resources department for details as to whether or not this Employer adopted plan design option applies. If, it is determined that a Participant has received a Qualified Reservist Distribution for the applicable Plan Year in excess of the amount allowed by the provision above, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay such excess to the Employer within sixty (60) days of receipt of such notification.

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PART 7: DEPENDENT CARE REIMBURSEMENTS

Q-1. What is my "Dependent Care Expense Reimbursement Account"?

You may elect to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Reimbursement Plan portion of the Plan. Under these provisions, you provide a source of pre-tax funds to reimburse yourself for your Eligible Dependent Care Expenses. You elect a specific level of salary deferrals and authorize Your Employer to make salary reductions, in lieu of receiving the corresponding amount of current pay. Your salary reductions are not taxable; therefore you save Social Security and certain income taxes on the amount of salary reductions you elect.

If you elect to reduce your income under the Dependent Care Reimbursement provisions of the Plan, a Dependent Care Reimbursement Account (the Account) will be set up in your name to keep a record of the salary deferrals you have made during the Plan Year. The "Account" is maintained for accounting purposes only; there is not an actual monetary account set up in your name nor are there actual deposits in the account. Interest is not accrued to your Account. Your salary reductions are accounted for, but the actual monetary salary deferrals are maintained as a general asset of your Employer. You may submit claims for reimbursements for up to the total amount of salary reductions you have deferred in the Plan Year.

Q-2. What is the minimum benefit I can elect?

If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. You may elect to defer any amount of salary you desire, subject to the minimum specified by the Plan. The minimum benefit is specified in Part 1: "Important Plan Information".

Q-3. What is the maximum benefit I can elect?

If you elect to participate in the Plan, you must make level salary reductions equal to the total annual amount elected over the course of the Plan Year. You may elect to defer any amount of salary you desire, subject to the maximum amounts specified below.

Status	Annual Maximum
Married, filing a joint return	$5,000
Married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free Dependent Care Reimbursements, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return or are single or a head of household for tax purposes.	$5,000
Married, residing together but file a separate federal income tax return	$2,500

In no event may your election exceed your taxable compensation (before your salary reduction under the Plan). Additionally, if you are married, your election may not exceed your spouse's actual or deemed Earned Income. Your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Dependents), for each month in which your spouse is either a full-time student or incapable of caring for himself or herself.

The maximum benefits outlined above are the federal maximums for each tax year, regardless of the number of employers you may have had during the year. If you participate in another employer's dependent care reimbursement Plan during the same calendar year, it is your responsibility to ensure that the combined federal maximums are not exceeded.

Q-4. How is my Account maintained?

When you complete the Election Form, you specify the amount of dependent care reimbursement you wish to elect for the Plan Year. During the Plan Year, contributions to your Dependent Care Reimbursement Account are set up as salary reductions from your gross income each paycheck and credited to your Dependent Care Reimbursement Account. (Your per-paycheck contribution is calculated by dividing the total annual amount elected by the number of pay periods remaining, so your salary reductions are equal throughout the Plan Year.) You are eligible for reimbursements up to an amount equal to your dependent care account balance at the time of your reimbursement request. You may never receive reimbursement in excess of your year-to-date contributions. Reimbursements are made from Your Employer's general assets.

For example, if you elect to contribute $4,200 per year to your Dependent Care Account and you are paid twice per month, your Account would be credited with $175 per pay period throughout the Plan Year. You would be eligible to receive reimbursements up to the cumulative amount contributed at the close of each pay period.

Q-5. What does "Use It or Lose It" Mean?

The most important Plan restriction is the "use it or lose it" rule. You must carefully estimate your annual dependent care expenses prior to your election. If you over-estimate your expenses and do not actually incur your estimated eligible

dependent care expenses by the Claims Incurred Deadline, your unused salary reduction contributions will be forfeited at the end of the Plan Year.

Q-6. What is the Claims Incurred Deadline?

Typically the Claims Incurred Deadline is December 31st (the end of the Plan Year) and you should always try to incur expenses equal to your election *during* the Plan Year. However, in some cases an employer may make an election to extend the Claims Incurred Deadline to allow for claims to be incurred up to 2½ months after the end of the Plan Year so that expenses that might otherwise be forfeited might be eligible for reimbursement.

There are many complex reasons (both administrative and financial) why your Employer may or may not elect to extend the Claims Incurred Deadline. It is important to note that it may only be elected in advance on an Employer-wide basis and exceptions cannot be made for a specific participant. Please check the Claims Incurred Deadline in Part 1: "Important Plan Information" to confirm the last date to incur claims under this Plan.

It is important to note that if your Claims Incurred Deadline is extended to allow claims to be incurred during the 2½ months following the Plan Year (refer to Part 1: "Important Plan Information"), you must be aware that all claims will be adjudicated in the order they are received (with full documentation). Additionally, claims will be applied to any balance in the prior Plan Year until that balance is exhausted; then, claims will be applied to any election in the current plan year. In certain circumstances, this may cause a problem that you must be aware of and that you may need to manage carefully in order to avoid losses.

Q-7. How do I receive reimbursement under the Plan?

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible dependent care expenses. When you incur an expense that is eligible for reimbursement, you must submit a claim to the Plan Administrator on the claim form provided. All claims must include a signed Claim Form along with full and complete documentation of the expense incurred. Required documentation includes written statements/bills from an independent third party which include the dependent's name, the provider name, the dates of care, and the amount charged. In order to receive reimbursement, Vita must have the Tax ID Number of the provider on file. The Tax ID Number could be an Employer ID Number or a Social Security Number. The Tax ID Number must be included in your first submission either of the claim form or documentation. Handwritten receipts are acceptable provided they are signed by the provider and they include all the required information. Copies of balance forward billing statements, cancelled checks, or any receipt without complete documentation outlined above are not considered sufficient documentation.

Provided you have commenced salary reductions, you will be reimbursed for your eligible dependent care expenses as soon as administratively feasible. The specific method by which you will receive your reimbursement is identified in Part 1: "Important Plan Information". Details of this reimbursement method are outlined in Part 8: "Reimbursement Methods". The specific claim reimbursement process is outlined in the welcome letter you receive with your claim kit after you formally elect. To have your claims processed as soon as possible, please read and follow the directions provided in the Claim Kit, which is mailed to your home after your election or received electronically via e-mail.

Q-8. What is the deadline for submitting claims?

You will have until the Claims Submission Deadline identified in Part 1: "Important Plan Information" to submit claims for eligible dependent care expenses incurred during the previous Plan Year. All claims must be submitted by the Claims Submission Deadline to be considered for reimbursement. Claims received after the Claims Submission Deadline are not eligible for reimbursement. Additionally, any claims received prior to the Claims Submission Deadline without complete documentation and/or where complete documentation is not submitted by the Claims Submission Deadline are not eligible for reimbursement.

If the Plan is terminated or there is a change in Contractor for Administrative Services prior to the end of the Plan Year for any reason, participants must submit any claims incurred prior to the termination date or date of change in Contractor for Administrative Services along with complete documentation by the date specified at the time of termination. If Your Employer goes out of business, claim submission deadlines may be significantly shortened and you may not be able to receive any reimbursement, despite having made contributions to your account.

Q-9. When must the Eligible Dependent Care Expenses be incurred?

Eligible dependent care expenses should be *incurred during* the Plan Year that you have elected to participate in the Plan. You may not be reimbursed for any expenses incurred before the Plan became effective, before your Election becomes effective, before you sign the election form, or after the close of the Plan Year. You may, however, be reimbursed for expenses incurred after your termination date, provided they are employment related and incurred prior to the Claims Incurred Deadline.

Q-10. Who is eligible to incur Dependent Care expenses?

Any child or individual who is a dependent of the Participant within the purview of Internal Revenue Code §152. If the dependent is a child, the child must be under the age of 13 years old. If the dependent is 13 years of age or older, they must be physically or mentally incapable of caring for himself or herself to qualify as an eligible dependent.

Q-11. What is an "Employment Related" expense?

IRS guidelines require that dependent care expenses must be employment related in order to qualify as eligible expenses. This means the employee's dependent incurs the expenses to enable the employee (and the employee's spouse, if married) to be gainfully employed. The IRS guidelines regarding what qualifies as employment related are very strict and require that you actually be at work or looking for work at the time the dependent care is provided.

Q-12. What is an "Eligible Dependent Care Expense"?

You may be reimbursed for employment-related dependent care expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a dependent on your federal income tax return; a spouse or any other tax qualified dependent who is mentally or physically incapable of caring for him or herself. Generally, these expenses must meet all of the following conditions for them to be eligible dependent care expenses:

The expenses are incurred for care rendered after the date of your election to receive Dependent Care Reimbursement and during the Plan Year to which it applies.

1. Each individual for whom you incur the expenses is:
   - A dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or
   - A spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
2. The expenses are incurred for the care of a dependent (as described above), or for related incidental household services, and are incurred to enable you and your spouse (if applicable) to be gainfully employed.
3. If the expenses are incurred for care provided outside your household and such expenses are incurred for the care of a dependent, mentally or physically incapable of caring for him or herself, who is age 13 or older, he or she must regularly spend at least 8 hours per day in your home.
4. If the expenses are incurred for care provided by a dependent day care center, the center must comply with all applicable state and local laws and regulations including licensing laws and regulations. (For example, in California if a facility provides care for more than six individuals not residing at the facility, then California law requires that the facility be licensed. In this case, the facility must be licensed in order to be an eligible expense under this Plan.)
5. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
6. The expenses must be primarily custodial in nature (that is, not primarily educational or recreational in nature).

If you have questions on eligible expenses, please contact Vita for assistance in seeking clarification prior to making an election to participate. If you plan on having an expense reimbursed and you later find out that it is not eligible, you may not change your election. The best resource for claim eligibility is the searchable database on the VitaFlex website at **www.vitaflex.net** or by calling the Vita Service Center. For additional information regarding questions on eligibility of certain expenses contact Vita at 650-966-1492 or at 800-424-3052 or via e-mail at **flex@vitamail.com**,

You are also encouraged to consult IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any questions. You may also consult IRS Publication 503, which outlines criteria for eligible dependent care expenses. However, please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 503, "Child and Dependent Care Expenses", or by other IRS guidance) that Your Employer and Vita have purposefully excluded from this Plan due to the ambiguity surrounding the eligibility of the expense. You may order a current copy of IRS Publication 503 by calling the IRS at 800-829-3676 or by visiting **www.irs.gov**.

Practically, these guidelines generally mean that the following types of expenses would be considered eligible, provided the expenses are for the care of a Qualifying Individual:

- Expenses paid to a dependent care center or dependent care provider.
- Expenses paid to an in-home dependent care provider.
- Expenses paid for education of a pre-school child which are incidental to and cannot be separated from the cost of dependent care.
- Expenses paid for summer camps that are custodial in nature.

Vita Administration Company retains full authority to make final determinations as to whether or not a claim is considered eligible for reimbursement under the guidelines of the Plan. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided. Please note that there are certain expenses considered eligible by the IRS (either by reference in Publication 503, Publication 17, or by other IRS guidance) that may not be eligible under this Plan due to the difficulty associated with documenting and administering reimbursement for these items.

In any circumstance where there is disagreement between the IRS guidelines (the IRS Code, IRS regulations, or phone advice provided by an IRS customer service representative) and the Plan Document and administrative policies of Vita will prevail as the governing practice.

Q-13. What dependent care expenses are not eligible?

Dependent care expenses must be primarily custodial in nature, as opposed to primarily educational or recreational. If a dependent care expense is primarily educational or recreational in nature, it is not an eligible expense. Expenses for classes, educational enrichment programs, or after-school programs that offer an educational element may not be eligible expenses. Examples of expenses that are not eligible include, but are not limited to: language classes, SCORE, tutoring,

gymnastics lessons, piano lessons, sports classes or leagues, and after-school learning centers. Marketing materials and discussions with staff of after school programs may also be considered to verify the custodial nature versus the educational nature of the program.

Summer camp dependent care expenses can be considered primarily custodial in nature or they may be considered primarily educational or recreational in nature. Each summer camp expense is reviewed individually to determine its eligibility. Factors that affect whether a camp is considered custodial in nature include, but are not limited to: daily length of the camp, nature of activities during the camp, and drop off and pick-up procedures of the camp. Camp marketing materials may also be reviewed to confirm the custodial nature versus the educational/recreational nature of the camp. Please note that overnight came is never eligible even if the amount of the day portion versus the night portion can be broken out.

Certain expenses related to dependent care are not considered eligible for reimbursement. These include, but are not limited to: diapering fees, transportation fees, and late payment fees.

If you have a question about whether a dependent care expense is eligible, please call for clarification prior to making an election to participate. If you plan to have a dependent care expense reimbursed and you later find out that it is not eligible, you may not change your election. For additional information regarding eligibility of certain expenses, contact Vita Administration Company at **flex@vitamail.com** or (650) 966-1492 or (800) 424-3052. Vita Administration Company retains full authority to make final determinations as to claim eligibility. Vita will take into account whether the expense is deemed eligible according to the IRS, whether the expense is eligible according to the Plan guidelines, and whether appropriate documentation has been provided.

Q-14. What documentation is required for a claim?

The IRS requires specific documentation to substantiate all eligible dependent care expenses. Expenses that do not have complete documentation cannot be reimbursed. For dependent care expenses a receipt is always necessary. The receipt must identify the dependent's name, the provider's name, the provider's Tax ID number or Social Security number, the dates that care was provided, and the amount charged for the care. Receipts for home day care may be hand written, but must include all of the above documentation and must include the signature of the provider.

Insufficient Documentation: The IRS has indicated that copies of cancelled checks alone are not considered sufficient documentation. Balance forward billing statements that do not outline the dates of care and all other required information identified above are also insufficient as well as documentation outlining the date that a dependent care payment was paid instead of outlining the specific dates of care.

Vita Administration Company has the authority to request and require any and all documentation it deems necessary to substantiate the eligibility of claims prior to reimbursement. Vita Administration Company retains full authority to confirm whether a claim is deemed eligible according to the IRS and whether appropriate documentation has been provided.

Q-15. What is the household and dependent care credit?

Federal tax law permits you to use your Dependent Care expenses as a credit against your federal income tax. However, this tax credit is *not available* to the extent the Dependent Care expenses are reimbursed to you under a Dependent Care Reimbursement Account. The general terms of the tax credit are as follows.

- If your adjusted gross income is less than $15,000, the tax credit is 35% of the qualifying Dependent care expenses that you pay during the year.
- Based on the current tax law, the tax credit will decrease from 35% to 20% of the qualifying expenses as your adjusted gross income increases from less than $15,000 to $43,000 for the year. The maximum credit of 35% is reduced by 1% for each $2,000 of your adjusted gross incomes between $15,000 and $43,000. The following chart outlines the percentage tax credit available based on varying levels of household adjusted gross income:

Less than $15,000	35%	$29,000	27%
$15,000	34%	$31,000	26%
$17,000	33%	$33,000	25%
$19,000	32%	$35,000	24%
$21,000	31%	$37,000	23%
$23,000	30%	$39,000	22%
$25,000	29%	$41,000	21%
$27,000	28%	$43,000 +	20%

- If your adjusted gross income is more than $43,000, the tax credit is 20% of the qualifying Dependent Care expenses that you pay during the year.
- To determine the tax credit, you may take into account only $3,000 of dependent care expenses for one Dependent, or $6,000 for two or more Dependents.

Illustration: Assume you have one Dependent who has incurred Eligible Dependent Care Expenses of $3,600, and that your adjusted gross income is $23,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage credit available at $23,000 is 30%. Thus, your tax credit would be $3,000 x 30% = $900. If you had incurred the same expenses for two or more Dependents, your credit

would have been $3,600 x 30% = $1,080, because the entire expense would have been taken into account, not just the first $3,000.

In some cases, it is more beneficial to take the tax credit rather than participating in the Dependent Care Reimbursement Plan. Because the amount of the dependent care tax credit depends on your adjusted gross income for the year, you must review your individual federal tax situation and determine if it is more beneficial for you to use the reimbursement under the Plan or elect to not be reimbursed and use the federal tax credit. To help you in this decision, you may obtain a copy of the federal income Tax Form 2441 “Child and Dependent Care Expenses” and its explanation.

Q-16. If I participate, can I still claim the household and dependent care credit on my federal income tax return?

Generally, no. You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. You must subtract any tax free reimbursements from the Dependent Care Reimbursement Plan from the maximum dependent care expenses that might otherwise be available or the calculation of the tax credit (the $3,000 or $6,000). Therefore, if you elect the maximum $5,000 dependent care benefit, and you have one dependent, you will not be eligible for a dependent care tax credit, even if you have additional dependent care expenses that exceed the $5,000 tax free benefit. However, if you have two or more dependents, you may be eligible for a tax credit on expenses between the $5,000 maximum benefit under the reimbursement Plan and the $6,000 maximum under the tax credit.

Q-17. When would I be better off to include the reimbursements in my income and claim the credit?

Generally, if your income marginal federal tax bracket is 15% or less, you will probably come out ahead by not participating in the dependent care reimbursement Plan and claiming the credits for dependent care and earned income. The higher your income, the more likely it is that you will benefit from the Dependent Care Reimbursement Plan. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., you will have to determine your own tax position individually in order to make the decision between taxable and tax-free benefits. Consult your tax advisor to confirm the details of your personal situation and the most advantageous election under this Plan.

Q-18. What if the dependent care expenses I incur are less than the amount I have elected?

Any unused amount in your Account will be forfeited. You will not be entitled to receive any direct or indirect payment of any difference between the actual dependent care expenses you have incurred and the annual coverage you have elected and/or the total amount of your actual salary reductions. Any un-reimbursed balance in your Account will be forfeited and restored to Your Employer if a claim for Eligible Dependent Care Expenses has not been submitted by the Claims Submission deadline (outlined in Part 1: “Important Plan Information”). Forfeited amounts are used to offset administrative expenses, Plan losses, and overall Plan costs.

Q-19. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not normally be taxed on your reimbursement benefits, up to the limits set out in Part 7, Question 3. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

PART 8: REIMBURSEMENT METHODS

Q-1. How is the money in my account reimbursed?

There are three basic methods of being reimbursed under the Plan. These various methods accommodate different administrative priorities and processes of different employers. Your Employer has made an election as to how all participants of Your Employer’s Plan will be reimbursed; you do not have a personal choice in the matter of reimbursement method. The specific method of reimbursement Your Employer has selected is outlined in Part 1: “Important Plan Information”. You will receive your reimbursement via one of the following three methods:

1. Payroll Reimbursement
2. Direct Reimbursement
3. Employer Reimbursement

Q-2. How does the Payroll Reimbursement Method Work?

Under the Payroll Reimbursement Method, you will receive your reimbursement directly in your paycheck from your Employer. After you submit a claim that is authorized for reimbursement, your Employer receives a report directing them to add your approved reimbursement amount to your paycheck. Reimbursement amounts are then added to your net pay on a tax-free basis. Your pay stub will identify the tax-free reimbursement amount under a specified code for Medical Reimbursements or Dependent Care Reimbursements. If your paycheck is being deposited into a personal bank account via direct deposit, the reimbursement will be included in your paycheck which is then directly deposited into your bank or savings institution. If your employment has been terminated and you are due a reimbursement, your reimbursement may be processed either through the payroll system (even though you have been terminated and don’t receive a normal paycheck) or through a separate manual check.

Q-3. How does the Direct Reimbursement Method Work?

Under the Direct Reimbursement Method, you will receive your reimbursement directly into your personal bank account. In most cases, this will occur via a direct deposit to your account. In some cases, this will occur via paper check. Direct deposit reimbursements are processed weekly, typically for deposit into personal bank accounts each Friday. If your employment has been terminated and you are due a reimbursement, you will still receive your reimbursements via this same method. In most cases, Vita will receive your bank account information from your Employer.

Please note, if your employer allows paper checks to be issued, your Employer is charged for every paper check that is processed. Your Employer and the VitaFlex Team would like to encourage you to receive your reimbursements via direct deposit, even when paper checks are an option provided by your Employer.

Q-4. How does the Employer Reimbursement Method Work?

Under the Employer Reimbursement Method, you will receive your reimbursement in a check form directly from your Employer. After you submit a claim that is authorized for reimbursement, your Employer receives a report directing them to make a reimbursement to you. These reimbursements are typically processed via a check. If your employment has been terminated and you are due a reimbursement, you will still receive your reimbursements via this same method.

Q-5. Are debit cards available under the Plan?

Certain plans have debit cards available for advance payment of eligible expenses. Your Employer will indicate whether debit cards are available under your Plan. There are many complex reasons (both administrative and financial) why Your Employer may or may not elect to offer debit card technology as an additional reimbursement method. If Your Employer offers debit cards the Q-6 through Q-11 of this section apply; otherwise, they do not apply.

Q-6. How do debit card transactions work?

In addition to one of the reimbursement methods outlined above, you may also receive money from your account via your electronic Debit Card. Your Debit Card transactions are considered “advanced” reimbursements, and, in most cases, are still subject to the standard claim documentation requirements, even though they are “advanced” reimbursements. Your debit card is linked directly to your Medical Flexible Spending Account but does not apply to any Dependent Care Reimbursement Accounts.

You may use your VitaFlex Debit Card to pay for eligible expenses without having to pay out of pocket expenses up front and then wait to be reimbursed. You may use your VitaFlex Debit Card to pay for eligible expenses at any provider with a Qualified Merchant Code. The merchant code is the transaction code used by the provider when they swipe debit card expenses, which classifies their type of business. Qualified Merchants include doctor’s offices, dentist offices, drugstores, pharmacies, and hospitals. Certain limited expenses will be exempt from the normal documentation requirements. Thus, in certain limited situations, you may swipe your debit card for eligible expenses and you will not have to submit additional documentation after the fact for those expenses.

Using the debit card does not mean that documentation requirements are eliminated entirely. It is important to save all your receipts! For most expenses, you must still submit receipts and documentation to substantiate that your claim is an eligible expense. This documentation rule was established by the IRS as a requirement for all debit card users under a Reimbursement Plan. The IRS outlines certain special exceptions when documentation is not required for debit card transactions, but for all other debit card transactions documentation is required.

Please note that debit cards become inactive on your date of termination. If you decide to extend your coverage under Federal COBRA, your debit card will not be reactivated.

The VitaFlex Debit Card has a five year life and must be kept by the participant from year to year. You will not be reissued a new Debit Card within a five year period which means that if you do not participate on a consecutive year basis, you will still be required to use the same Debit Card. If your debit card is lost or stolen, you will be charged the replacement fee and it will be deducted from your Medical Flexible Spending Account election.

Q-7. What are the documentation requirements for debit card transactions?

The IRS requires that all Flexible Spending Account claims have third party documentation in order to substantiate the eligibility of the claim. There are two different types of transactions for your debit card.

- Swipe Type #1: Always requires submission of documentation after the fact.
- Swipe Type #2: No additional documentation is required.

Swipe Type #2 expenses are considered “auto-adjudicated.” No additional documentation is required because they follow the specific guidelines outlined by the IRS for expenses that do not require follow-up documentation. You are NOT expected to know or to guess which type of swipe you have incurred. If your expense is a Swipe Type #1 and thus requires documentation, you will be sent a letter from Vita (within two to three weeks of purchase) requesting the necessary documentation. The letter will reference the specific date on which you incurred the expense by swiping your card. The letter will also contain a Swipe Type #1 documentation form that you can fill out and submit with the documentation. You must submit the necessary documentation by the date listed on the VitaFlex documentation request that will be sent to you.

If your expense is a Swipe Type #2 expense, VitaFlex will also send you a letter outlining the expense is substantiated and there is no further action on your part necessary.

Q-8. What happens if I don't submit the needed documentation?

If you do not send the required documentation by the date that is listed on your VitaFlex documentation request, your debit card will be "turned off". You will then receive a second request for the outstanding documentation. If you do not send the documentation by the second date listed on your documentation request, the expense will be presumed not eligible, since the required documentation was not received in a timely manner. At that point, you will be required to repay the ineligible expense to the Plan. To repay money for ineligible expenses into the Plan, your employer will garnish your paycheck or require you to pay the money directly to them. If you have terminated employment you will need to repay the money to the Plan by writing a check or by an alternate repayment strategy at the discretion of your former employer. If you do not repay your Employer, your account will be frozen and you will not be allowed to submit claims for reimbursement. When your Employer creates your W-2 for the calendar year, the amount of the ineligible claim will become taxable in order to keep the Plan compliant.

Q-9. What happens if I charge an ineligible expense to my debit card?

When you activate your debit card, you are accepting responsibility to only use it to purchase items that are eligible under the Plan. Each time you swipe the card, you are confirming this responsibility. If, after you send the documentation, it is deemed that the expense is not eligible, you will be required to repay the ineligible expense to the Plan. To repay money for ineligible expenses into the Plan, your employer will garnish your paycheck or require you to pay the money directly to them. If you have terminated employment you will need to repay the money to the Plan by writing a check or by an alternate repayment strategy at the discretion of your former employer. If you do not repay your Employer, your account will be frozen and you will not be allowed to submit claims for reimbursement. When your Employer creates your W-2 for the calendar year, the amount of the ineligible claim will become taxable in order to keep the Plan compliant. Please note that use of the debit card to purchase known ineligible expenses is considered fraud against the Plan. Persistent purchasing of ineligible items may result in your card being permanently turned off and other potential action against you.

Q-10. When is a debit card transaction recorded on my account?

Your debit card transactions are NOT necessarily always recorded on the date you actually swipe your card and make your purchase. All debit card purchases have a "settlement date" which is the date the merchant actually completes the transaction. MasterCard debit card merchants have up to two (2) business days after the card swipe occurs to "settle" a debit card transaction. While many merchants settle card swipe transactions the same business day, some settlement dates may be delayed. The automatic claims processing system in VitaFlex keys your transaction off of the settlement date, not the actual transaction date.

This could be important if you swipe your card near your employment termination date or near the end of the Plan Year. For example, if you swipe your card on December 30th, but the MasterCard merchant actually settled the transaction on January 2nd, the purchase will have a transaction date of December 30th in the current Plan Year, but a settlement date of January 2nd in the following Plan Year. In this case, automatic claims processing system will deny the expense as incurred outside the Plan Year.

If you have made an election in the following Plan Year (or plan to elect COBRA continuation coverage in the event of this situation occurring near your employment termination date), this may not be a problem for you. However, if this automatic claims process causes a problem such that you might forfeit a portion of your election, you may make a request that the transaction date for claims incurring purposes be changed from the settlement date to the actual purchase date. VitaFlex will honor such requests if they are received by Vita up to three (3) weeks after the settlement date. This is the same three (3) week period that you would normally be given to submit documentation for debit card expenses (when such documentation is necessary). Requests to override the settlement date will be denied if they received more than three (3) weeks after the settlement date. All requests to change the transaction date to the actual purchase date so that the claim may be considered "incurred" on the actual purchase date must be received by Vita within three (3) weeks of the settlement date or they cannot be processed.

Q-11. Where can I use my debit card to pay for over-the-counter items?

You will not be able to use your debit card at non-health care merchants such as supermarkets and grocery stores or health care related merchants that are deemed by the IRS to sell less than 90% of health care related items unless they have a special inventory system in place. Your card will be declined at stores that have not implemented this system and you will have to provide another form of payment. This special inventory system codes each item in the store as eligible or ineligible under a Health Flexible Spending Account. Ineligible items are not allowed to be purchased using a Flexible Spending Account debit card. For example, you will be allowed to purchase a bottle of Nyquil using your Flexible Spending Account debit card but not a bottle of vitamins. If you try and purchase an ineligible item, your card will be declined. A list of participating merchants is available on our website at **www.vitaflex.net**.

PART 9: PRIVACY

Q-1. Does the Plan comply with the HIPAA Privacy Rule?

This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Vita recognizes that a fundamental element of maintaining effective customer privacy procedures is to provide reasonable protection against unauthorized access to customer information and protected health information. Therefore, we have established appropriate security standards and procedures to guard against any unauthorized access to customer information.

Q-2. How is the privacy of my health information protected?

Vita collects personal, financial and health-related information that is necessary for the processing of claims, for fulfilling legal and regulatory requirements, and for assisting clients with policy or administration questions. We maintain pertinent personal identifying data (such as a Social Security Number). We also maintain records on any health conditions disclosed or provided to us in claims for reimbursement in order to comply with IRS guidelines.

We may collect non-public personal information as well as protected health information about you from many sources, including information we receive about you on applications or other forms and information about your transactions with us. Vita places strict limits on who receives specific information about customer accounts and other personally identifiable financial data and protected health information. Vita never rents or sells your personal information to anyone.

If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Official named in Your Employer's Privacy Policy. The Privacy Notice for Vita Administration Company can be referenced at **www.vitacompanies.com/privacy.asp**.

Q-3. Who is allowed to access my account information?

You as the employee are the only person allowed to receive account information through any mode of communication (i.e. via e-mail or over the phone from the Vita Service Center). Every Plan Year, you must name and sign off on individuals who you would like to grant access to your account information. This information must be received in writing (either via U.S. Mail using Vita's "Account Correspondence Form" or via e-mail at **flex@vitamail.com**). Vita Administration Company will keep this information on file and you must notify Vita if you would like to change an individual's status during the Plan Year.

PART 10: ERISA RIGHTS AND PLAN QUESTIONS

Q-1. What are my ERISA Rights?

As a Participant in the Medical Reimbursement Plan and health insurance under the premium contribution Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be entitled to the following rights:

1. Receive Information about the Plan

   You have a right to 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.

2. Obtain Copies of Plan Documents

   You have a right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description or Plan Detail Document. The Administrator may make a reasonable charge for the copies.

3. Continue Group Health Plan Coverage

   You have a right to continue health care coverage for yourself, spouse or dependents if there is loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this document and the documents governing the Plan on the rules governing your COBRA Continuation rights.

4. Credit for Pre-existing Condition Exclusion Periods

   You have a right to the 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 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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Q-2. How are my ERISA Rights protected?

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of Your Employer's Plan. The people who operate your Plan are called "fiduciaries" of the Plan. The fiduciaries have a duty to administer the Plan prudently and in the interest of you and the other Plan Participants 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 benefit from the Plan, or from exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of the documents relating to the decision without charge, and to appeal any denial, all with certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 per 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 medical child support order, you may file suit in a 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. If you file a suit, the court will decide who must pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the court costs and legal fees. However, if you lose, the court may order you to pay the court costs and legal fees (for example, if the court finds your claim is frivolous).

Q-3. What if I have questions about the Plan or ERISA?

If you have any questions about this statement or your rights under ERISA, you should contact the local office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory. Alternatively, you may contact the national office. Following are the local and national listings for these offices:

San Francisco Regional Office
Employee Benefits Security Administration (EBSA)
90 7th Street, Suite 11-300
San Francisco, CA 94103
Phone: (415) 625-2481

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210
Phone: (866) 444-3272

Q-4. What if I have a general question about the Plan or VitaFlex administration?

If you have general VitaFlex Plan questions or any question about the administration of the plan, please feel free to contact the Vita offices.

Mailing Address
Vita Administration Company
900 North Shoreline Boulevard
Mountain View, CA 94043

Phone/E-mail Inquiries
Phone: (650) 966-1492
(800) 424-3052
E-mail: **flex@vitamail.com**

Claims Submission:
Fax: (650) 964-FLEX (3539)
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