ANDOVER USD 385

WELFARE BENEFIT PLAN

Summary Plan Description

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ANDOVER USD 385 WELFARE BENEFIT PLAN

Andover USD 385 ("Employer") maintains the Andover USD 385 Welfare Benefit Plan ("Plan") for the exclusive benefit of, and to provide benefits to, its Eligible Employees, their legal Spouses, and their eligible dependents.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. ***If there is a conflict between the plan documents and this SPD, the plan documents will control.***

(1) General Information

(a) *Type of Plan.* The Plan is a cafeteria plan.

(b) *Pre-Tax Benefits.* Participants in the Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits (or a portion of the cost of benefits if partially paid by the Employer) provided by one or more of the following plans maintained by the Employer:

(i) Andover USD 385 Medical Plan ("Medical Plan");

(ii) Andover USD 385 Dental Plan ("Dental Plan");

(iii) Andover USD 385 Health Flexible Spending Account ("Health FSA");

(iv) Andover USD 385 Dependent Care Assistance Plan ("DCAP");

(v) Andover USD 385 Vision Plan ("Vision Plan");

(vi) Andover USD 385 Cancer Plan ("Cancer Plan"); and/or

(vii) Certain benefit options under the Andover USD 385 Guardian Plan ("Guardian Plan").

Each of the above Pre-Tax Benefits is governed by a plan document. Please refer to such document for information regarding specific terms and conditions associated with each plan. This SPD serves as the summary plan description for each of these Pre-Tax Benefits. A summary of each of these plans is provided later in this SPD.

The amount by which your salary is reduced to purchase benefits, and any benefits paid to you under these Pre-Tax Benefits, will not be included in your taxable income for federal income tax purposes and is not subject to FICA taxes.

(c) *After-Tax Benefits.* Participants in the Plan may reduce their salary on an after-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:

(i) Andover USD 385 Short Term Disability Plan ("Short Term Disability Plan");

(ii) Andover USD 385 Permanent Life Plan ("Permanent Life Plan"); and/or

(iii) Certain benefit options under the Andover USD 385 Guardian Plan ("Guardian Plan").

This SPD serves as the summary plan description for each of these plans. A summary of each of these plans is provided later in this SPD.

(d) *Employer-Paid Benefit.* The Andover USD 385 Employee Assistance Program Plan ("EAP Plan") is an Employer-Paid Benefit available through the Plan.

This SPD serves as the summary plan description for this plan. A summary of this plan is provided later in this SPD.

(e) *Group Health Plans.* Certain special rules apply to benefits that are considered to be "group health plans." Therefore, whenever you see the term "group health plan" in this SPD, it is referring to the following benefits under the Plan:"

(i) Andover USD 385 Medical Plan;

(ii) Andover USD 385 Dental Plan;

(iii) Andover USD 385 Health Flexible Spending Account;

(iv) Andover USD 385 Vision Plan; and

(v) Andover USD 385 Cancer Plan.

(f) *Employer.* The name, address, telephone number, and federal tax identification number of the Employer are:

Andover USD 385
1432 N. Andover Road
Andover, KS 67002
(316) 218-4660
EIN: 48-6035687

(g) *Plan Administrator.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"). The Plan Administrator is vested with full discretionary

authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to be enrolled in and/or receive any benefit under the terms of the Plan. The Plan Administrator has the authority to take such corrective action as it might consider to be appropriate in the event that an error in administering the Plan has taken place. For example, if there is a failure to deduct the correct amount of a Participant's election, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.

(h) *Service of Process.* The name of the person designated as the Agent for Service of Legal Process is Sherame Kneisel, whose address is the same as the Employer's address. Service of Legal Process may also be made upon a Plan trustee or the Plan Administrator.

(i) *Plan Year.* The Plan Year is the calendar year.

(j) *Spouse.* When the word "Spouse" is used in this SPD, it means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which you currently reside. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of the Plan if (i) his/her marriage to you has been terminated by a court having jurisdiction over you or the individual or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

(k) *Dependent.* When the word "Dependent" is used in this SPD, it means, for purposes of the Health FSA only, the following:

(i) *Children Through Age 26.* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, until such child attains age 26 (or until such child attains age 18 in the case of a legal guardianship). Children placed with you for adoption and children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(ii) *Disabled Children Above Age 26.* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical

disability and for whom you are the major source of financial support, from the end of the calendar month in which the child attains age 26.

(iii) *Non-Children Dependents.* Any of your relatives who reside in your home, are claimed by you as a tax dependent, and meet the definition of a tax dependent under Code § 152.

(2) Participation in the Plan

You will automatically become a Participant in the Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(a) *Eligibility Conditions.* To be eligible to participate in the Plan (i.e., to be an "Eligible Employee"), the following conditions must be met:

(i) *Employee.* You must be an individual employed by the Employer;

(ii) *Regularly Scheduled Hours per Week.* Your regularly scheduled workweek must ordinarily equal or exceed 30 hours per week. For purposes of the Plan, this is considered to be "full-time";

(iii) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified on the Employer's payroll records as a "leased" employee; or (C) for purposes of participating in the Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code; and

(iv) *Employee Assistance Program Plan.* All Employees are eligible for the EAP Plan regardless of their work schedule and will enter the EAP Plan immediately.

(b) *Plan Entry Date.*

(i) *General Rule.* If you are an Eligible Employee, you will become a Participant on the first day of the month following 30 days of continuous, active employment, even if you do not choose to purchase benefits under one or more of the Pre-Tax Benefits and/or After-Tax Benefits.

EXAMPLE #1: You begin working as a full-time employee on March 15. You complete 30 days of employment with the Employer on April 14. You will become a Participant in the Plan on May 1.

EXAMPLE #2: You change from part-time to full-time on March 15. You will automatically enter the Plan on the first day of the next month, which is April 1.

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as you continue to satisfy the conditions for being an Eligible Employee, as summarized above. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

(i) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in the Plan, you may still continue to participate in the Plan if you are on (A) a paid leave approved by the Employer; (B) unpaid leave under the Family and Medical Leave Act ("FMLA") if the FMLA is applicable to the Employer; provided, however, any period of unpaid leave shall run concurrently with any FMLA leave; or (C) unpaid leave through the end of the month.

(ii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as "unpaid leave" for purposes of plan eligibility. However, nothing in this subsection shall preclude you, if you are on FMLA leave from maintaining eligibility during such FMLA leave.

(iii) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two weeks or less.

(iv) *Special Rule for Certain Pre-Tax Benefits.* If you are participating in a Pre-Tax Benefit and your employment is terminated before the end of a pay period or the end of the month, your participation in the Plan may continue through the end of the pay period and/or the month (depending on the underlying Pre-Tax Benefit).

EXAMPLE: You participate in the Medical Plan and the Health FSA. You are paid on the 1st and 15th of each month. You terminate employment on July 5. You will remain an Eligible Employee in the Plan for purposes of participating in the Medical Plan on a pre-tax basis through the end of the month. You will also remain an Eligible Employee in the Plan for purposes of participating in the Health FSA through July 15.

(3) Pre-Tax Benefit Options – Participant Elections

To purchase benefits on a pre-tax basis through the Plan, you must elect to do so by completing and returning a salary reduction agreement to the Plan Administrator. This is known as an "Election." Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

(a) *How to make an Election.* To make an Election, you must complete a salary reduction agreement and return the completed salary reduction agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election change form. The Plan

Administrator may require the salary reduction agreement or the Election change form to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

(b) *When to make an Election.*

(i) *General Rule.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year.

(ii) *Initial Election by New Participants.* If you are a newly Eligible Employee, an Election will normally need to be made prior to the date you enter the Plan as a Participant.

(iii) *Election Changes.* An Election change during the middle of a Plan Year must be made no later than 30 days after the event that allows an Election change to be made, except that an Election change made in connection with certain HIPAA special enrollment rights may be made within 60 days after the event as further described in (3)(d)(ii) below.

(c) *Failure to make an Election.*

(i) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.

(ii) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new salary reduction agreement for a subsequent Plan Year will be treated as a decision on your part to retain your existing Elections for the new Plan Year. However, if you have elected to put money into the Health FSA or DCAP, your Election for those plans will be reduced to zero dollars for any subsequent Plan Years.

(d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, IRS regulations, and informal guidance from the IRS.

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

(i) *Change in Status.* If there is a "change in status" and the Election change is consistent with the "change in status," then the following events may constitute a "change in status":

(A) A change in your marital status;

(B) A change in the number of your dependents;

C) A change in the employment status of yourself, your Spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your Spouse, or your dependent are regularly scheduled to work, but only if the change in hours affects your eligibility for benefits under the Plan, or any of the other Benefit Plans, or your Spouse's or dependent's eligibility under a benefit plan of their employer;

(D) A reduction in your hours such that you will no longer average at least 30 hours per week, even though that reduction in hours does not affect your eligibility for benefits under a Group Health Plan (other than a Health FSA). However, in order to make an election change on the basis of a reduction in hours that does not affect Group Health Plan eligibility, you (and any Spouse and/or dependents who are covered through you) must enroll in another group health plan that provides "minimum essential coverage" no later than the first day of the second month following the month in which your coverage under the Group Health Plan was revoked;

(E) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Benefit Plan;

(F) A change in residence for yourself, your Spouse, or your dependent if it affects that person's eligibility for benefits; and/or

(G) You enroll in a Qualified Health Plan through an Exchange/Health Insurance Marketplace (the "Marketplace") established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a special enrollment period in the Marketplace or by having enrolled during the Marketplace's annual open enrollment period. However, in order to make an Election change on this basis, you (and any Spouse and/or dependents who are covered through you) must enroll in the Qualified Health Plan and have such coverage take effect no later than the day immediately following the day that your coverage under the Medical Plan is terminated.

Whether an Election change is consistent with the "change in status" will be determined by the Plan Administrator in accordance with IRS regulations and prevailing IRS guidance.

(ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must provide a "special enrollment" period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth,

or adoption. These individuals also include individuals who become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Unlike with the other Election change events, you have 60 days to enroll an individual if the Election change event is a HIPAA special enrollment right related to eligibility for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

(iii) *Change in Coverage of Your Spouse or Dependent.* If there is a change in the coverage of your Spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a "corresponding" Election change. For this exception to apply, one of the following conditions must be met: (A) The plan year of the other employer's cafeteria plan is different than the Plan Year of the Plan; or (B) the cafeteria plan of the other employer permits only those Election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of, and corresponds with, the change made under the plan of the other employer.

EXAMPLE: You have elected to provide medical coverage for your family under the Employer's Medical Plan. Your Spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your Spouse elects "family coverage" under the medical plan of that employer. The plan year of that employer is different than the Plan Year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through the Plan.

(iv) *Loss of Governmental/Educational Institution Group Health Coverage (Does not apply to the Health FSA or DCAP).* If you, your Spouse, or your dependent loses group health coverage and the coverage was sponsored by a governmental or educational institution, you may make an Election change to add coverage for the persons who are losing coverage. For purposes of this provision, group health coverage sponsored by a governmental or educational institution includes a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government or a tribal organization, a state health benefits risk pool, or a foreign government health plan.

(v) *"Significant" Curtailment in Coverage (Does not apply to the Health FSA).*

(A) *Without Loss of Coverage.* If coverage under a plan is "significantly curtailed," but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage

under a plan is "significantly curtailed" only if there is an overall reduction in the coverage provided to participants in the plan.

(B) *With Loss of Coverage.* If coverage under a plan is "significantly curtailed" and that curtailment constitutes a "loss of coverage" for you, your Spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a "loss of coverage" means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your Spouse, or your dependent is currently receiving treatment.

(C) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is "significant," whether a curtailment represents a "loss of coverage" with respect to a particular individual, and whether a substitute benefit option provides "similar coverage."

(vi) *Addition or Improvement of a Benefit Option (Does not apply to the Health FSA).* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is significantly improved, you may make an Election change to add that option.

(vii) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a plan. You may also be able to change your Election under the "change in status" exception discussed above.

(viii) *To Comply with a Judgment, Decree, or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree, or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree, or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.

(ix) *Entitlement to Medicare/Medicaid.* If you, your Spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the Employer's Group Health Plan. If you, your Spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the Employer's Group Health Plan.

(x) *Significant Change in Cost of Coverage (Does not apply to the Health FSA).* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage all together.

If your share of the premium for coverage under a benefit option decreases by a significant amount, you may decrease your Election by a corresponding amount or, if you are not currently enrolled in that benefit option, you may elect to become covered under that benefit option.

Whether there has been a "significant" change in cost and whether another benefit option provides "similar coverage" will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

In addition to the Election changes, which you may make in the middle of a Plan Year, as summarized above, the Plan Administrator may automatically change the amount of your Election in the middle of a Plan Year if there is an "insignificant" change in the cost of the coverage you have elected. Whether there has been an "insignificant" change in cost will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(e) *Effective Date of Elections.*

(i) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.

(ii) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election change form and salary reduction agreement are received by the Plan Administrator. This includes both Election changes and the initial Elections made by new Participants. Under IRS regulations, Elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided. The only exception to this prohibition is for newborn children and newly adopted dependents who are enrolled in a Group Health Plan pursuant to HIPAA "special enrollment" rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.

(f) *Special Rule for Former Participants Rehired Within 30 Days of Termination.* If you are rehired within 30 days after the date on which your employment was terminated, you will be reinstated in the Plan with the same Elections you had before your employment was terminated unless (i) you would be permitted to make an Election change for some reason other than the change in your employment with the Employer or (ii) the Plan

Year ended on or after the date your employment was terminated, but before the date you were rehired.

(g) *Special Rule for Health FSAs.* You may *not* change your Election under the Health FSA in the middle of a Plan Year except as follows:

(i) You may begin to participate in the Health FSA if you are eligible, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above;

(ii) You may increase your Election as long as you do not exceed the maximum Election amount permitted under the Health FSA and provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; or

(iii) You may decrease your Election, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; however, you may not reduce your Election amount below the total amount you have already been reimbursed.

EXAMPLE: During the Annual Enrollment Period, you make an Election of $1,200 for your Health FSA for the Plan Year. To pay for this benefit, your salary is reduced by $100 per month. Suppose that after three months, you have contributed a total of $300 into your Health FSA, you have been reimbursed $400, and you experience a qualifying Election change event. You may change your Election for the Plan Year to any amount equal to or greater than $400.

Continuing with the above example, suppose you change your Election amount to $600 instead of $1,200. Because you have already been reimbursed $400, only $200 will be available to you for reimbursement through the end of the Plan Year.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

(4) After-Tax Benefit Option - Participant Elections

You may make and/or change your Elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such Election change will take effect on the earliest administratively practicable date after the request to change an after-tax Election is received by the Plan Administrator.

(5) Waiver of Coverage under the Medical Plan

If you are a "classified employee" (i.e., hourly or annualized hourly employee) who is eligible for coverage under the Medical Plan and you waive coverage under the Medical Plan, you may be eligible for a monthly Employer contribution based upon the number of months you are scheduled to work, ***provided*** you timely submit adequate proof (as determined in the discretion of the Plan Administrator) of other group medical coverage (or Tricare). The amount of such taxable contribution is determined annually at the Employer's discretion.

(6) Coverage Under the Fully-Insured Group Health Plans

The Employer maintains the following Group Health Plans, which are fully insured through the insurance companies specified below:

(i) A Medical Plan that pays benefits pursuant to the terms and conditions of a group contract with Blue Cross Blue Shield of Kansas ("BCBS"), 1133 SW Topeka Boulevard, Topeka, Kansas 66629-0001;

(ii) A Dental Plan that pays benefits pursuant to the terms and conditions of a group contract with Delta Dental of Kansas, P.O. Box 789769, Wichita, KS 67278;

(iii) A Vision Plan that pays benefits pursuant to the terms and conditions of a group contract with Surency Life & Health, P.O. Box 789773, Wichita, KS 67278; and

(iv) A Cancer Plan that pays benefits pursuant to the terms and conditions of a group contract with Guardian, 7 Hanover Square, New York, NY 10004.

(a) *Type of Plans.* The above plans are fully-insured Group Health Plans. They are administered by the Employer; however, benefit claims are processed and paid by the applicable insurance company, who is the insurer and Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the plan entry dates for the above listed fully-insured Group Health Plans are the same as those for the Plan, as described in Section (2) above.

(c) *Enrollment in the Plan.* **To become a Participant in one or more of the fully-insured Group Health Plans, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your date of entry in the applicable Group Health Plan. **If you do not elect to participate in a Group Health Plan, you will not receive any benefits under the particular Group Health Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the applicable Group Health Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the applicable group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you

are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(ii) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in a Group Health Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Group Health Plan if you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP), you may be able to enroll yourself and/or your dependents in the Group Health Plan if you request enrollment within 60 days after you or your dependents become eligible for such assistance. Similarly, if you lose eligibility for Medicaid or SCHIP coverage, you have special enrollment rights in a Group Health Plan, provided you request enrollment within 60 days after you or your dependents lose eligibility for Medicaid or SCHIP coverage.

(d) *Plan Benefits.* If you elect to participate in one or more of the above listed fully-insured Group Health Plans, benefits will be provided by the Employer pursuant to the terms and conditions of the applicable group contract between the Employer and the applicable insurance company. If elected, these Group Health Plans provide you and/or your dependents with comprehensive medical, dental, vision, and/or cancer coverage, as applicable. The applicable insurance company has prepared materials which explain the benefits under these fully-insured Group Health Plans in detail. If you have not received these materials from the applicable insurance company, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* The applicable insurance company is solely obligated to pay for benefits provided under the applicable corresponding group contract. The Employer makes no promise, and will have no obligation, to provide or pay for any benefits under the above-mentioned group contracts.

(f) *Premiums.* The monthly premiums for insurance coverage under the Group Health Plans are determined by the applicable insurance company, and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Your portion of the premiums for the Medical Plan, Dental Plan, Vision Plan, and Cancer Plan may be paid on a pre-tax basis through the Plan.

(g) *Medical, Dental, Vision, and Cancer Treatment.* The fully insured Group Health Plans do not provide medical, dental, vision, and/or cancer treatment or advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate medical, dental, vision, or cancer treatment, as applicable**. The fact that some expense may not be eligible for reimbursement by a particular Group Health Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under one of the above listed fully-insured Group Health Plans, you should follow the procedures outlined in the materials prepared by the applicable insurance company. The Plan Administrator, upon your request, will assist you in making these claims. The insurance company has been delegated full discretionary authority to make all determinations regarding the administration and payment of benefit claims under the Group Health Plans, in accordance with the terms of the applicable group contract.

(i) *Explanation of Benefits*. If you participate in one of the fully-insured Group Health Plans, you will receive an explanation of benefits (EOB) under the Group Health Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the Claims Administrator and provide an alternate address.

(j) *Termination of Coverage.* If you participate in one or more of the above listed Group Health Plans, your participation ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the fully-insured Group Health Plan.

Your coverage for benefits under one or more of the fully-insured Group Health Plans, as applicable, ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(7) Health Flexible Spending Account

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Health FSA entry date are the same as those for the Plan, as described in Section (2) above.

(c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator, as set forth in Section (3)(a) through (c) above. **If you do not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.** However, if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) and (g) of this SPD), you may enroll in the Health FSA in the middle of the Plan Year.

(d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:

(i) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Plan (see Section (15)(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.

(ii) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected $1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to $1,000 under this alternative.

(e) *Effective Date of Election.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you are a newly Eligible Employee, your Election will take effect when you become a Participant in the Plan.

EXAMPLE: You begin working as a full-time employee on March 15. You complete 30 days of employment with the Employer on April 14. You timely elect to participate in the Health FSA. Your Election takes effect on May 1.

(iii) *Election Made Following an Election Change Event.* If you elect to participate within 30 days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your child is born. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within 30 days after March 15, (that is, by April 14). If you do not elect to enter the Health FSA within 30 days after this "change in status," you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

EXAMPLE: You elect to reduce your salary by $1,200 for the Plan Year. Therefore, $1,200 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.

If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount, you will lose the unused portion.

EXAMPLE: Assume you elect to reduce your salary by $1,200 for medical expenses, but incur only $1,000 of uninsured expenses for the Plan Year. As required by IRS regulations, you will forfeit the remaining $200. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.

If the Employer determines after the claims Run-Out Period and after processing all pending claims that the total premiums paid by all participants in the Health FSA exceed the total reimbursements paid out, the Plan will have a surplus. Such surplus will be used to offset reasonable administrative costs. Any surplus remaining after such

costs are paid will be used to reduce the required premiums in the following Plan Year. If you are a participant in the Health FSA on the date of the first payroll following the date on which the amount of surplus has been determined, you will receive a reduction in the cost of your premium, known as a "premium holiday."

If the Health FSA is terminated by the Employer before or at the end of the Plan Year, then the Employer will determine whether or not there is a surplus. There is a surplus if the total contributions from all Participants exceed the total Health FSA reimbursements. This determination will not be made until after the claims Run-Out Period and after all pending claims have been processed. The Employer will use the surplus, if any, to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed to all individuals who were participating in the Health FSA on the date of the Plan's termination. The amount of remaining surplus will be divided by the number of participants entitled to the distribution in order to determine each person's share. In no case will the surplus be allocated to you based directly or indirectly on your claims experience or on the amount of your annual election.

(g) *Maximum Benefit Amount.* Under the Health FSA, if you or your dependents incur a "qualified medical expense" for which you submit a timely claim for reimbursement, you will receive a reimbursement for the portion of that expense that is not covered by medical or dental insurance; however, your reimbursements may not exceed the maximum reimbursement amount.

(i) *Maximum Reimbursement Amount – General Rule.* The maximum reimbursement amount for a Plan Year, plus the amount, if any, of the contributions made by the Employer to the Participant's Health FSA for that Plan Year, may not exceed the total amount that you have elected to contribute to the Health FSA for that Plan Year.

(ii) *Limits on Contributions to a Health FSA.* The amount that you elect to contribute to the Health FSA for a Plan Year may not exceed the maximum dollar limit that is established each year by the Employer nor may it be lesser than the minimum dollar limit, if any, established each year by the Employer. The maximum dollar limit, in turn, may not exceed the statutory dollar limit established in the Code, as adjusted by the IRS for periodic cost-of-living increases. The dollar limit(s) established by the Employer will be communicated in the enrollment materials for the Health FSA. The Plan Administrator will also provide information about this dollar limit upon request.

(iii) *Maximum Reimbursement Amount – Run-Out Periods.* A claim that is incurred during the previous Plan Year and which is submitted for reimbursement during the Plan's Run-Out Period will count against the maximum reimbursement amount for the previous Plan Year and not the Plan Year during which reimbursement is made.

(iv) *Maximum Reimbursement Amount – Grace Periods.* A claim that is incurred during the current Plan Year and which is submitted for reimbursement during the Plan's Grace Period will count against the maximum reimbursement amount for the previous Plan Year (and not the current Plan Year) if it is paid out of amounts remaining from the previous Plan Year.

(h) *Qualified Medical Expenses.* The "qualified medical expenses" for which you (or your Spouse or Dependent) are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other means. It also includes menstrual care products as defined in Code § 223(d)(2)(D). Typical expenses include, but are not limited to:

(i) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;

(ii) Medical, dental and/or vision care expenses that have not otherwise been reimbursed;

(iii) Certain over-the-counter drugs permitted by Code § 213(d); and

(iv) Certain menstrual care products, such as tampons and pads.

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under IRS rules, a qualified medical expense is generally considered to be "incurred" when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses <u>not</u> eligible for reimbursement by the Health FSA include, but are not limited to:

(i) Those reimbursed through any other policy or plan, including Medicare or other federal programs;

(ii) Those incurred before you enroll in the Health FSA;

(iii) Those incurred in any year other than the year for which Health FSA contributions are made;

(iv) Those claimed as a deduction or credit for federal income tax purposes; and

(v) Those the IRS would not allow as deductions for federal income tax purposes, except for certain over-the-counter drugs.

(i) *Special Grace Period Rule.* For purposes of the timing of claims for reimbursements under this Health FSA, described in Section (o) below, "Grace Period" means the period that begins immediately following the close of the Plan Year and ends on the March 15 immediately following the close of the Plan Year. Eligible expenses *incurred* during the Grace Period may be reimbursed from any funds remaining in your Health FSA for the immediately preceding Plan Year.

(i) *Eligibility for Grace Period Rule.* You may also make your claim for benefits for expenses incurred during the Grace Period related to that Plan Year against your account for that Plan Year if you are either: (A) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (B) a Qualified Beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA on the last day of the Plan Year. Such claims must be made within the Run-Out Period following the close of the Plan Year.

(ii) *Order of Reimbursement under Grace Period Rule.* Claims submitted for reimbursement during the Grace Period (or the Run-Out Period, if later) will be first charged against any remaining amount in your Health FSA account for the previous Plan Year. However, the Claims Administrator may reallocate from which "pot" of money (i.e., the remaining money or "new" money), a claim is paid in order to help you use up "old" or remaining money (if possible) during the Run-Out Period. All "qualified medical expenses" incurred during the Grace Period must be submitted in paper form and not through the use of an electronic payment card, such as a debit card.

(iii) *EXAMPLE 1:* At the end of Plan Year one, you have $1,000 remaining in your Health FSA. You elect to contribute $2,500 to your Health FSA for Plan Year two. Also at the end of Plan Year one, you have a medical procedure done which costs you $1,000. You do *not* immediately turn in your claim for $1,000. You do, however, turn in claims for expenses incurred in the Grace Period which follows, totaling $200. Your claims totaling $200 will be paid out of the remaining money in your account from Plan Year one because they are eligible Grace Period expenses.

(iv) *EXAMPLE 2:* Continuing with the above example, you turn in the claim for your $1,000 operation (incurred in Plan Year one) before the end of the Run-Out Period. You have $800 remaining in your account for Plan Year one. However, because the Claims Administrator can reallocate expenses which are properly submitted, the Claims Administrator will reallocate the $200 claim in Example 1 as a Plan Year two expense. This will leave you with $1,000 in your account from Plan Year one from which the $1,000 claim may be paid. Once it is paid, you will have used up what was left in your account from Plan Year one and will have used $200 from your account for Plan Year two.

(j) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends 75 days following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(k) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Medical Expenses. The electronic payment card may only be used at merchants and service providers which are authorized by the Employer.

(l) *How to Submit a Claim.*

(i) *Claims Forms.* Except as provided in (ii) below, in the event you have a claim for benefits under the Health FSA, you must submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

(A) The amount, date incurred and nature of each expense;

(B) The name of the person, organization or entity with whom the expense was incurred;

(C) The name of the person for whom the expense was incurred;

(D) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(E) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your Health FSA through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this Health FSA; other payments may require further substantiation by you to the Health FSA. Please note that, if you present your electronic payment card as payment for a medical expense and it is denied at the point-of-sale (i.e., when the service or item is provided), that denial of payment will *not* constitute an initial claim denial under these procedures.

(m) *Claims Administrator.* Surency Life & Health will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Surency Life & Health has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims.

(n) *Recoupment of Underwithheld Amounts.* In the event that not enough salary is withheld from your paycheck, resulting in insufficient funds in your Health FSA, the Employer will seek recoupment of the amount of the insufficient withholding.

(o) *Timing of Claims.* Subject to the Special Grace Period Rule, you may submit your claim for benefits under the Health FSA during the Plan Year in which the expenses are incurred or within the Run-Out Period following the close of the Plan Year. If you terminate your participation in the Health FSA or if the Employer terminates the Health FSA, you must submit your claim for reimbursement for that Plan Year no later than 75 days after the date of your termination and no later than 75 days after the date the Employer terminates the Health FSA, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than September 14 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

(p) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator will promptly furnish you, within 30 days of receipt of the claim, written notice:

(i) Setting forth the reason for the denial;

(ii) Making reference to pertinent Health FSA provisions upon which the denial is based;

(iii) Describing any additional material or information which is necessary and why;

(iv) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(v) Explaining the claim review procedure set forth herein, including applicable time limits and a statement of your right to bring a civil action following an adverse determination upon review.

(q) *Extension of Time Frame for Deciding Claims.* The Claims Administrator may seek one extension of up to 15 days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial 30-day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least 45 days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you respond to the request for information.

(r) *Appealing a Claim Denial*. If your claim is denied, in whole or in part, you have 180 days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

(s) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than 60 days after receipt of your request for review.

(t) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (i) state the reason for the decision, (ii) refer to the Health FSA provisions upon which it is based, (iii) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, (iv) describe any voluntary appeals procedures, and (v) state your right to bring a civil action.

(u) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, Surency Life & Health (or the Plan Administrator) may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. Surency Life & Health and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, Surency Life & Health (or the Plan Administrator), prior to making payments under the Plan, may require you to file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.

(v) *Termination of Coverage.* Your participation in the Health FSA ends on whichever of the following dates occurs first:

(i) The last day of the pay period in which you cease to be an Eligible Employee;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the Health FSA.

Your coverage for benefits under the Health FSA ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD. You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in your Health FSA as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(w) *Qualified Reservist Distributions (QRDs).* A "qualified reservist distribution" is a distribution of all or a portion of your account balance if you are called to active military service, provided the call to service is for a period of 180 days or more or for an indefinite period of time.

(i) *Amount of QRD*. Unless a lesser amount is specifically requested, the QRD will be the total of your contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

(ii) *Timeframe for Requesting a QRD*. You must request a QRD on or after the date you are called to active military service and prior to the end of the Run-Out Period immediately following the end of the Plan Year in which you are called to service.

(iii) *Timeframe for Claims Administrator to Respond to a QRD Request*. The Claims Administrator shall respond to any timely request for a QRD within 60 days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth above in this Health FSA section of the SPD, except that the time frame set forth in (p) above is 60 days instead of 30 days.

(iv) *Eligible Claims*. If you request a QRD, you forfeit the right to receive reimbursements for Qualified Medical Expenses incurred after the date of your last day of active employment. You will be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment or if later, the date of your QRD request, provided that the total dollar amount of such claims does not exceed the amount of your election minus the sum of your QRD and prior reimbursements received for the Plan Year.

(v) *No Penalty on QRD*. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in your gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

(8) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan, as described in Section (2) above.

(c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**

(d) *Effective Date of Election.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you are a newly eligible employee, your Election will take effect when you become a Participant in the Plan.

EXAMPLE: You begin working as a full-time employee on March 15. You complete 30 days of employment with the Employer on April 14. You timely elect to participate in the DCAP. Your Election takes effect on May 1.

(e) *Election Made Following an Election Change Event.* If you elect to participate within 30 days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your Spouse begins a full-time job. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within 30 days after March 15, (that is, by April 14). If you do not elect to enter the DCAP within 30 days after this "change in status," you will not have a second opportunity to enter the DCAP until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.

(g) *Maximum Benefit Amount.* The benefits you receive under this DCAP may not exceed the maximum amount specified in the Internal Revenue Code or be less than the minimum set by the employer. The maximum amount specified in the Internal Revenue Code is $5,000 (or $2,500 if you are a married person filing a separate return) *per calendar year* or, if less, your "earned income limitation." The maximum benefit amount *per Plan Year* is also $5,000 (or $2,500 if you are a married person filing a separate return) or, if less, your "earned income limitation." The "earned income limitation" is your earned income, if you are not married. If you are married, the earned income limitation is the lesser of your earned income or your Spouse's earned income.

(h) *IRS "Use It or Lose It" Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.

(i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in the Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Plan (see Section (3)(d) of this SPD).

(j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP***. In many cases, you may save more money by receiving tax-free reimbursements under the Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The "qualified" dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(i) *Qualified Dependent.* A qualified dependent is:

(A) Your child (as defined in Internal Revenue Code § 152) who is under age 13 and is your "qualifying child" as defined in Code § 152(a)(1); or

(B) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:

(1) Is physically or mentally incapable of caring for himself/herself; and

(2) Is living with you for more than one-half of the calendar year.

(C) Your Spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for federal income tax purposes, the child must be in your custody for at least six months out of the year to be a qualified dependent.

(ii) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

(A) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse, or housekeeper in your home, as long as part of their service benefits the qualified dependent.

(B) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations. If such expenses are incurred for services performed outside your home for an individual described in (k)(i)(B) above, then such individual must be living with you at least eight hours a day.

(C) Pre-school care, before- and after-school care, and day camp during school vacation.

(iii) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:

(A) Expenses paid through another policy or plan providing dependent care benefits to you or your Spouse.

(B) Amounts paid to your child who is age 18 or younger for babysitting or care of a qualified dependent.

(C) Expenses paid to a person whom you or your Spouse are entitled to claim as a dependent for federal income tax purposes.

(D) Expenses incurred prior to becoming a Participant in the DCAP.

(E) Education expenses for a child in kindergarten or any higher grade.

(F) Overnight care at a convalescent nursing home for a dependent Spouse or relative.

(G) Overnight camp.

(H) Expenses for lessons, tutoring, or certain types of transportation expenses.

(I) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.

(l) *Grace Period.* For purposes of the timing of claims for reimbursements under this DCAP, described in Section (o) below, "Grace Period" means the period that begins immediately following the close of the Plan Year and ends on the March 15 immediately following the end of the Plan Year.

Eligible expenses *incurred* during the Grace Period may be reimbursed from any funds remaining in your DCAP for the immediately preceding Plan Year.

(m) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends 75 days following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(n) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Dependent Care Expenses. The electronic payment card may only be used at service providers which are authorized by the Employer.

(o) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.

(i) *Claims Administrator.* The Employer has designated Surency Life & Health to act as the Claims Administrator for the DCAP. As the Claims Administrator, Surency Life & Health shall have the sole authority to grant or deny any claims for benefits under the Plan. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your DCAP through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this DCAP Plan; other payments may require further substantiation by you to the DCAP Plan.

(iii) *When to Submit a Claim.* You may submit your claim for reimbursement for expenses you incurred during the Plan Year in which incurred or within the Run-Out Period following the close of that Plan Year. If you terminate your participation in the DCAP, or if the Employer terminates the DCAP, you must submit your claim for reimbursement for that Plan Year no later than 75 days after the date your participation in the Plan terminates or the date the Employer terminates the Plan, respectively. However, if you cease participation in the DCAP before the end of the Plan Year, you may continue to incur claims and submit such claims for reimbursement through the end of the Run-Out Period following the close of the Plan Year.

(A) *Special Grace Period Rule.* You may also make your claim for benefits for expenses incurred during the Grace Period related to that Plan Year against your account for that Plan Year if you are a Participant with DCAP coverage that is in effect on the last day of that Plan Year. Such claims must be made within the Run-Out Period following the close of the Plan Year.

Claims submitted for reimbursement during the Grace Period (or the Run-Out Period, if later) will be first charged against any remaining amount in your DCAP account for the previous Plan Year, unless you specify otherwise on your claims form. All "qualified dependent care expenses" incurred during the Grace Period must be submitted in paper form and not through the use of an electronic payment card, such as a debit card.

EXAMPLE #1: At the end of Plan Year one, you have $400 remaining in your DCAP. You elect to contribute $5,000 to your DCAP for Plan Year two. During the Grace Period which follows, you pay your daycare provider $400 to take care of your child. You immediately turn in your claim for $400. Your claim will be paid out of the remaining money in your account from Plan Year one.

EXAMPLE #2: Continuing with the above example, you find an additional $50 in receipts for dependent care expenses *incurred* in Plan Year one. You turn in these claims after the claim for $400 that you paid to the daycare provider, but before the end of the Run-Out Period. This expense is not eligible for reimbursement because it was incurred in Plan Year one and you have already depleted your account for Plan Year one.

(iv) *Claims Decisions and the Right to Appeal*. Within a reasonable time, not exceeding 90 days (unless the Claims Administrator notifies you of an extension of up to 90 days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.

(v) *Payment of Claims*. Approved claims will be paid directly to you. No claims will be paid to the provider of any services.

(vi) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.

(p) *Termination of Coverage.* Your participation in the DCAP ends on whichever of the following dates occurs first:

(i) The last day of the pay period in which you cease to be an Eligible Employee; except that you may remain a Participant for purposes of incurring additional "qualified dependent care expenses" prior to the end of the Plan Year for purposes of being reimbursed from any money left in your account on the date your participation would otherwise have ended.

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution;

(iv) The date the Employer terminates the DCAP; or

(v) You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds the funds in your DCAP as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(9) Employer-Paid Coverage

The Employer maintains the following benefit for which the premiums are one hundred percent paid by the Employer:

(i) An Employee Assistance Program Plan that pays benefits under an insurance contract with Guardian, 7 Hanover Square, New York, NY 10004.

(a) *Type of Plans.* The above listed benefit is administered by the Employer; however, benefit claims are processed by the above-named insurance company, which also acts as the Claims Administrator. The above listed benefit is an Employer-Paid Benefit under the Plan.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the entry date for the Employer Paid Benefits are the same as those for the Plan, as described in Section (2) above.

(c) *Enrollment in the Plans.* **To become a Participant in the Employer Paid Benefits, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your entry date.

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Employer Paid Benefits.

(d) *Plan Benefits.* You will be insured under a group contract issued by the insurance company. This group contract provides you with an employee assistance program. The insurance company has prepared materials which explain the benefits of the group contract in detail. The insurance company will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* The insurance company is solely obligated to pay for the benefits provided under the group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Employer Paid Benefits are determined by above-listed insurance company and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will pay one hundred percent of the monthly premium cost.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Employer Paid Benefits, you should follow the procedures outlined in the materials prepared by the insurance company. The Plan Administrator, upon your request, will assist you in making these claims. The insurance company has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Employer Paid Benefits ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The end of a period for which a required contribution was last paid by the Employer, taking into account any grace periods required by law;

(iii) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(iv) The day the Employer terminates the Employer Paid Benefit.

Your coverage for benefits under the Employer Paid Benefits ends with the termination of your participation. However, you may be eligible for a conversion contract offered by the insurance company. Please refer to the appropriate group contract for further details.

(10) After-Tax Benefit Plan

The Employer maintains certain welfare benefit plans pursuant to insurance contracts (which are not Group Health Plans and are not provided through Guardian) that you may elect to participate in on an after-tax basis. The following are "after-tax benefits" under the Plan:

(i) A Short Term Disability Plan that pays benefits under an insurance contract with Guardian, 7 Hanover Square, New York, NY 10004.

(ii) A Permanent Life Plan that pays benefits under an individual policy of insurance with US Alliance Life and Security Company, 4123 SW Gage Center Drive, Suite 240, Topeka, KS 66604.

(a) *Type of Plan.* The After-Tax Benefit Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the entry dates for the After-Tax Benefit Plan are the same as those for the Plan, as described in Section (2).

(c) *Enrollment in the Plan.* **To become a Participant in the After-Tax Benefit Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your After-Tax Benefit Plan entry date. **If you do not elect to participate in one of the after-tax benefit plan options listed above under the After-Tax Benefit Plan, you will not receive any benefits under that particular after-tax benefit option.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in one of the after-tax benefit options offered under this After-Tax Benefit Plan.

(d) *Plan Benefits.* If you elect to participate in one of the above-listed after-tax benefit options, you will be insured under a group contract or individual policy issued by the insurance company. This group contract or individual policy provides you and, in some cases, your dependents with disability insurance. The insurance company has prepared materials which explain the benefits of the group contract or individual policy in detail. The insurance company will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* The insurance company is solely obligated to pay for the benefits provided under the corresponding group contract or individual policy. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract or individual policy.

(f) *Premiums.* The monthly premiums for insurance coverage under the After-Tax Benefit Plan are determined by the insurance company and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums must be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under one of the above-listed after-tax benefit options, you should follow the procedures outlined in the materials prepared by the insurance company. The Plan Administrator, upon your request, will assist you in making these claims. The insurance company has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of its group contract or individual policy.

(h) *Termination of Coverage.* Your participation in one of the after-tax benefit options ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the applicable insurance group contract or individual policy – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the applicable insurance group contract or individual policy – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the After-Tax Benefit Plan.

Your coverage for benefits under the After-Tax Benefit Plan ends with the termination of your participation. However, you may be eligible for a conversion contract. Please refer to the group contract or individual policy for further details.

(11) Guardian Plan

The Employer maintains the Guardian Plan that permits Participants to elect to receive benefits under one or more insurance contracts issued by Guardian, 7 Hanover Square, New York, NY 10004.

(a) *Type of Plan.* The Guardian Plan is administered by the Employer; however, benefit claims are processed and paid by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Guardian Plan entry date are the same as those for the Plan, as described in Section (2).

(c) *Enrollment in the Plan.* **To become a Participant in the Guardian Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Guardian Plan entry date. **If you do not elect to participate in the Guardian Plan, you will not receive any benefits under the Guardian Plan.**

(d) *Plan Benefits.* If you elect to participate in the Guardian Plan, you will be able to select from the following policies, whether they be individual policies of insurance or group contracts, which are issued by Guardian:

(i) Accident Plan;

(ii) Hospital Indemnity Plan;

(iii) Critical Illness Plan; and/or

(iv) Voluntary Life Plan.

You will be insured under either individual contracts or group contracts issued by Guardian. The contracts provide you (and your dependents, if family coverage is selected) with various types of insurance. Guardian has prepared materials which explain the benefits of each individual policy or group contract, as applicable, in detail. Guardian will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Guardian is solely obligated to pay for the benefits provided under the Guardian Plan. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the Guardian Plan.

(f) *Premiums.* The monthly premiums for insurance coverage under the various individual policies or group contracts, as applicable, listed in (d) above are determined by Guardian and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay one hundred percent of the monthly premium cost. Premiums for the benefits listed in (i) and (ii) must be paid on a pre-tax basis through the Plan; premiums for the benefits listed in (iii) and (iv) must be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Guardian Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the individual policy of insurance or group contract, as applicable.

(h) *Termination of Coverage.* Your participation in the Guardian Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the applicable insurance policy – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the applicable insurance policy – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Guardian Plan.

Your coverage for benefits under the Guardian Plan ends with the termination of your participation. However, if you are covered under an individual insurance policy, you may be able to remain covered under the individual insurance policy outside the Plan. Similarly, if you are covered under a group contract, you may be able to remain covered under an *individual* insurance policy outside the Plan. Please refer to the individual policies or the group contract, as applicable, for further details.

(12) COBRA Coverage for Group Health Plans

Special Note: This Section only applies if your Employer is required to offer COBRA continuation coverage. Generally, your Employer is required to offer COBRA continuation coverage unless the "small employer" exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than 20*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has 20 or more employees as determined under COBRA**, this Section will apply to an employee covered under a Group Health Plan sponsored by the Employer and to such employee's covered Spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

COBRA coverage is a temporary extension of coverage under Group Health Plans, under certain circumstances, when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Group Health Plans when group health coverage would otherwise be lost. **This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, the Dental Plan, the Vision Plan, and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the Group Health Plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

(a) *Qualified Beneficiary.* After a qualifying event (described below) occurs, and any required notice of that event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children may become qualified beneficiaries and may be entitled to elect COBRA if coverage under a Group Health Plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under NMSN may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

(b) *Continuation Coverage.* Continuation coverage is the same coverage that the Group Health Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Group Health Plan as other participants or

beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events with respect to each type of qualified beneficiary are as follows:

(i) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:

(A) Your hours of employment are reduced; or

(B) Your employment ends for any reason other than for gross misconduct.

(ii) *Spouse.* If you are the covered Spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your Spouse dies;

(B) Your Spouse's hours of employment are reduced;

(C) Your Spouse's employment ends for any reason other than for gross misconduct;

(D) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(E) You become divorced or legally separated from your Spouse. If your Spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

(iii) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your parent-employee dies;

(B) Your parent-employee's hours of employment are reduced;

(C) Your parent-employee's employment ends for any reason other than for gross misconduct;

(D) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

(E) Your parents become divorced or legally separated; or

(F) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(d) *FMLA Leave.* If you take FMLA leave and do not return to work at the end of the leave, you (and your Spouse and dependent children, if any) will be entitled to elect COBRA if you, your Spouse, and dependent children, if any, (i) were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (ii) will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Group Health Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

(e) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he/she has been reimbursed less money than he/she has contributed.

(i) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

(ii) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Plan Administrator for more information.

(iii) *Grace Period Rule.* If you are a COBRA beneficiary and are covered under the Health FSA on the last day of the Plan Year, you may continue coverage through the Grace Period (as defined in the Health FSA section of this SPD).

(f) ***COBRA Notice Procedures.*** When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with these Notice Procedures. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding such qualifying events.**

Warning: If your notice is late or if you do not follow these Notice Procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

(i) *Notices Must Be In Writing And Submitted On Plan Forms.* Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You the may obtain copies of required forms from the Plan Administrator). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

(ii) *How, When, And Where To Send Notices.* You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided on the first page of this SPD.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Section of the SPD.)

(iii) *Information Required For All Notices.* Any notice you provide must include: (A) the name of the Plan; (B) the name and address of the employee who is (or was) covered under the Plan; (C) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (D) the qualifying event and the date it happened; and (E) the certification, signature, name, address, and telephone number of the person providing the notice.

(iv) *Additional Information Required For Notice of Divorce Or Legal Separation.* If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

(v) *Additional Information Required For Notice Of Disability.* Any notice of disability must include: (A) the name and address of the disabled qualified beneficiary; (B) the date that the qualified beneficiary became disabled; (C) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (D) the date that the Social Security Administration made its determination; (E) a copy of the Social Security Administration's determination; and (F) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

(vi) *Additional Information Required For Notice Of Second Qualifying Event.* Any notice of a second qualifying event must include: (A) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (B) the second qualifying event and the date that it happened; and (C) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

(vii) *Who May Provide Notices.* The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

(g) *Electing COBRA Coverage*. Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for one, several, or for all dependent children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

(h) *Sixty-Day Election Period.* A qualified beneficiary must elect coverage in writing within 60 days of losing coverage under the Plan (or, if later, within 60 days of being provided a COBRA election notice), using the Plan's Election form and following the procedures specified on the Election form. (A copy of the Plan's Election form may be obtained

from the Plan Administrator.) The Election form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election form. If you mail your Election, it must be postmarked no later than the last day of the 60-day Election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

(i) *Failure to Return Election Form.* **If you or your covered Spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**

(ii) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he/she may change his/her mind as long as a completed Election form is furnished before the due date.

(iii) *Elections Under More Than One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health benefits under the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he/she may elect COBRA under any or all of the group health benefits under the Plan, and in which he/she was covered on the day before the qualifying event.

(i) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in Subsection (k) below.

(i) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to 18 months for the former employee, the Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(ii) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to 18 months for the employee, Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(iii) *Death of Employee*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

(iv) *Employee Entitlement to Medicare*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

(v) *Divorce or Legal Separation*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

vi) *Loss of Dependent Status*. COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.

(vii) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the Plan Year in which the qualifying event occurred.

(j) *Extension of Maximum Coverage Period (Not applicable to Health FSA).* If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his/her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)

(i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

(ii) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce, or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.

(iii) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

These extensions in subparagraphs (i) through (iii) above are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within 30 days of entitlement in accordance with the Plan's Notice Procedures found in Section (f) above.

(iv) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the Plan Year in which the initial qualifying event occurred.

(A) *Grace Period Exception*. Notwithstanding the above rule for Health FSAs, coverage will continue through the Grace Period (as defined in the Health FSA section of this SPD) for COBRA qualified beneficiaries covered on the last day of the Plan Year.

(k) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:

(i) Any required premium is not paid before the end of the grace period;

(ii) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan;

(iii) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(iv) The employer ceases to provide any Group Health Plan for its employees;

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage, for example, if a Participant or beneficiary engages in fraudulent activities against the Plan.

(l) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (or, in the case of an extension of continuation coverage due to a disability, one hundred fifty percent) of the cost to the Group Health Plan (including both employer and employee contributions) for coverage of a similarly-

situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

(m) *First Payment.* All COBRA premiums must be paid by check or money order, unless your COBRA administrator accepts a debit card. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election form. However, you must make your first payment for COBRA coverage within 45 days after the date of your Election. (This is the date the Election notice is post-marked, if mailed, or the date your Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated on the Election notice (unless, as stated above, your COBRA administrator accepts payment via debit card). You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the 45th day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

(n) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month, for each qualified beneficiary, will be disclosed in the Election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29 and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

(o) *Grace Periods*. Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly

payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.

(p) *Children Born to or Placed for Adoption.* A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

(q) *Alternate Recipients Under NMSNs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified National Medical Support Notice ("NMSN") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

(r) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

(s) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights under COBRA, HIPAA, and other laws affecting group health plans, contact the nearest regional or district office of the U.S. DOL's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through this website.)

(13) Special Retiree Coverage for Kansas Municipal Employees

If you "retire" (as defined below) with KPERS at the time of your termination of employment with the Employer, you (and any Spouse and/or dependents who are covered through you at the time of your retirement) may elect to continue coverage in a Group Health Plan (other than a Health FSA) if each of the conditions set forth below are satisfied:

(a) *Waiver of COBRA.* You waive your right to elect COBRA continuation coverage.

(b) *Timely Election to Continue Coverage*. You affirmatively elect to continue coverage under a Group Health Plan (other than a Health FSA) no later than 30 days after your retirement from employment with the Employer.

Note: For purposes of this special retiree coverage, the term "retire" means that you have terminated employment and are receiving a retirement or disability benefit for your service with the Employer.

(c) *Coverage of Your Spouse and/or Dependents.* If you elect to continue coverage under this special retiree continuation coverage, you may also elect to cover your Spouse and/or dependent(s) who were covered through you under the Group Health Plan (other than a Health FSA) as of your retirement from employment with the Employer. In order for any such individuals to be covered, however, they also must waive their right to elect COBRA continuation coverage. The coverage of such Spouse and/or dependent(s) shall terminate upon the earliest occurrence of the following events:

(i) Your coverage under the Group Health Plan terminates;

(ii) You turn age 65;

(iii) You fail to make a required premium payment on a timely basis;

(iv) Your Spouse and/or dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or

(v) The Employer terminates the Group Health Plan.

(d) *Payment of Premium.* You must pay the entire cost of coverage for this retiree continuation coverage. Although the exact premiums will be determined by your Employer, the Employer may also require that you pay an administrative fee of up to twenty-five percent of the cost of the coverage.

(e) *Termination of Continuation Coverage*. Your special retiree continuation coverage will terminate upon the earliest occurrence of the following events:

(i) You turn age 65;

(ii) You become covered, or become eligible to be covered, under another employer's group health plan;

Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.

(iii) You fail to make a required premium payment on a timely basis; or

(iv) The Employer terminates the Group Health Plan.

If you elect coverage pursuant to this Section, you may terminate the coverage at any time, provided, however, such coverage cannot be reinstated once terminated.

(14) USERRA Continuation Rights

If you are absent from employment as a result of military service, you will have the right to elect continuation coverage for a period of up to 24 months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than 31 days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than 30 days, you must pay the entire cost of coverage plus an additional two percent.

(b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your Employer's group health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

(15) Group Health Plan Claims Procedures (Not applicable to the Health FSA)

Payment by the Claims Administrator is based on data furnished by you. In order to collect benefits under the Plan, you must first provide the Claims Administrator with information about your claim for benefits.

Claims made for benefits under the fully-insured Group Health Plans, and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the insurer. Unless otherwise stated in your applicable insurance policy, before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in your policy. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided in your policy of insurance. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Unless otherwise stated in your applicable insurance policy, following the Plan's issuance of a final adverse benefit determination, you will have 180 days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

(16) Miscellaneous

(a) *National Medical Support Notice.* Participants in a Group Health Plan and their beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing the determination of whether an order is a ("NMSN").

(b) *Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(i) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive compensation from the Employer during your leave).

(ii) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA. If you fail to remit your premium payments within 30 days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate your coverage retroactive to the date the unpaid premium payment was due.

(c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under the Plan, including, but not limited to, a rebate of premiums previously paid, proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

(d) *Returns of Benefit Payments Made in Error*. The Plan shall have the right to reimbursement from you, your covered dependents, or assignees for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which you, your covered dependents, or assignees were not entitled.

(17) Notice of Hospital Rights for Newborns and Mothers

HIPAA requires this SPD to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(18) Notice of Rights under the Women's Health and Cancer Rights Act of 1998

The Employer is required by federal law to provide the following notice:

If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a participant or beneficiary who is receiving benefits in connection with a mastectomy and that person's attending physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of mastectomies, including lymph edemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan's annual deductibles and co-payment requirements.

(19) Right of Employer to Amend or Terminate

The Employer may at any time amend or terminate the Plan, including any of the plans that are summarized in this SPD, by a written instrument signed by the Superintendent of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

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APPENDIX A
SPECIAL ELIGIBILITY RULES UNDER LOOK-BACK MEASUREMENT METHOD

Although the Plan ordinarily requires that an Employee be *regularly scheduled to work at least 30 hours per week* in order to be eligible to participate in the Plan, certain part-time, variable hour, and seasonal workers may be eligible for coverage if they average at least 30 hours per week during the applicable Look-Back Measurement Period. These rules, which were established under regulations adopted pursuant to the Patient Protection and Affordable Care Act ("PPACA"), are extremely complicated and are set forth in detail in the Addendum 1 to the Plan. What follows is simply a general summary of how the Look-Back Measurement Method works. If you have additional questions, please contact the Plan Administrator.

Ongoing Employees

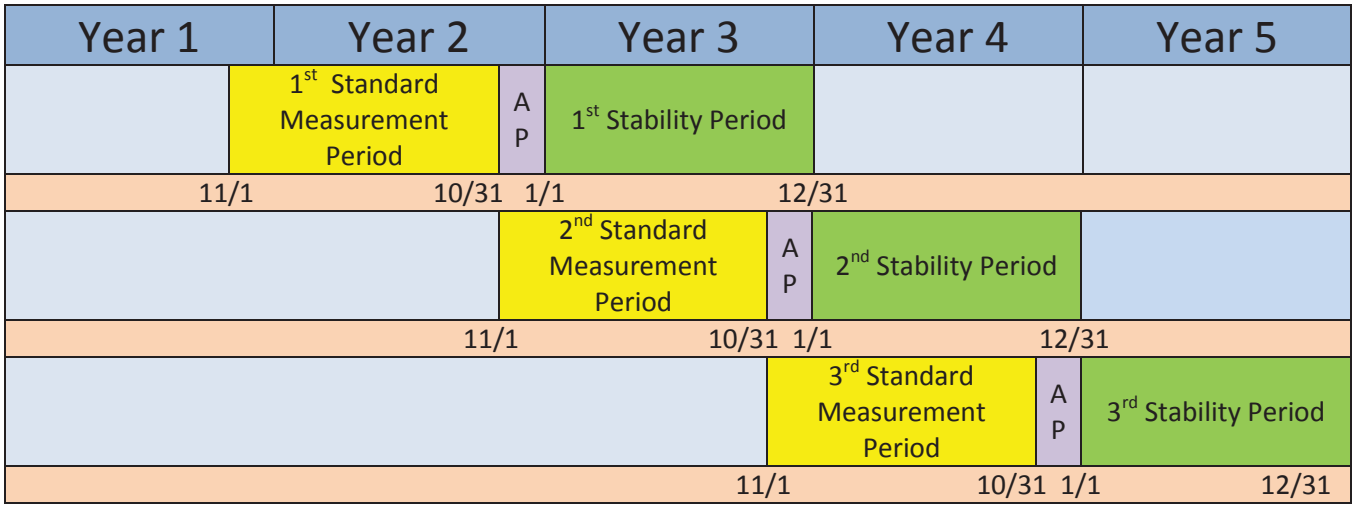
In general, for any Employee who is (i) not already regularly scheduled to work at least 30 hours per week and (ii) not categorically excluded from eligibility for the Plan regardless of hours worked, the Employer will add up the Employee's hours over a specified 12-month period of time (referred to as the "Standard Measurement Period") and determine if the Employee averaged at least 30 hours per week during that 12-month period. If the Employee *did* average at least 30 hours per week during the Standard Measurement Period, then he/she will be considered full-time (and thus will be offered coverage under the Plan) during the 12-month Stability Period that follows, and is associated with, that Standard Measurement Period. This is true regardless of how many hours the Employee actually works during that Stability Period.

If, on the other hand, the Employee *did not* average at least 30 hours per week during the Standard Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the 12-month Stability Period that follows the Standard Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Stability Period.

In addition, the Employer will be using an "Administrative Period" of approximately 30-60 days as a buffer between the Standard Measurement Period and Stability Period. This Administrative Period will be used by the Employer to count up the Employees' hours and to serve as an open enrollment period, if applicable.

The rules described above apply to all Employees who were employed by the Employer as of the first day of the Standard Measurement Period. These individuals are all referred to as "Ongoing Employees."

Although the Look-Back Measurement Method is complicated, the chart that appears at the top of the next page is designed to provide a visual illustration of what this Look-Back Measurement Method will look like for Ongoing Employees. As you can see from each of the three rows, the Standard Measurement Period and Stability Period will run for the same length of time and same time frame each year. So an individual may be deemed to be a "full-time" employee (and thus offered coverage) during one year's Stability Period (based on his/her hours in the preceding Standard Measurement Period), but then not be deemed a "full-time" employee (and thus not offered coverage) during some other year's Stability Period.



New Employees

A similar, but slightly different rule is used for *new employees*. A "New Employee" is any part-time, variable hour, or seasonal employee who was not employed by the Employer as of the first day of the Standard Measurement Period. A New Employee who, at the time of hire, is expected to average at least 30 hours per week will be treated as full-time immediately and offered coverage no later than the first day following the end of any applicable waiting period. But if the New Employee is a part-time, variable hour, or seasonal employee, the New Employee will *not* be eligible to enter the Plan unless he/she averages 30 hours per week during his/her Initial Measurement Period as described below. Instead, the New Employee's hours will be tracked using measurement and stability periods similar to those used for Ongoing Employees.

Basically, the Employer will start tracking the hours of the New Employee (who is either a part-time, variable hour, or seasonal employee) immediately – or almost immediately – after the New Employee begins employment. This tracking period is known as the "Initial Measurement Period." The Initial Measurement Period will be 12 months, and it will begin on approximately the first day of the first month after the New Employee's start date. If the New Employee *did* average at least 30 hours per week during this Initial Measurement Period, then he/she will be considered full-time (and thus will be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows, and is associated with, that Initial Measurement Period. This is true regardless of how many hours the Employee actually works during that Initial Stability Period.

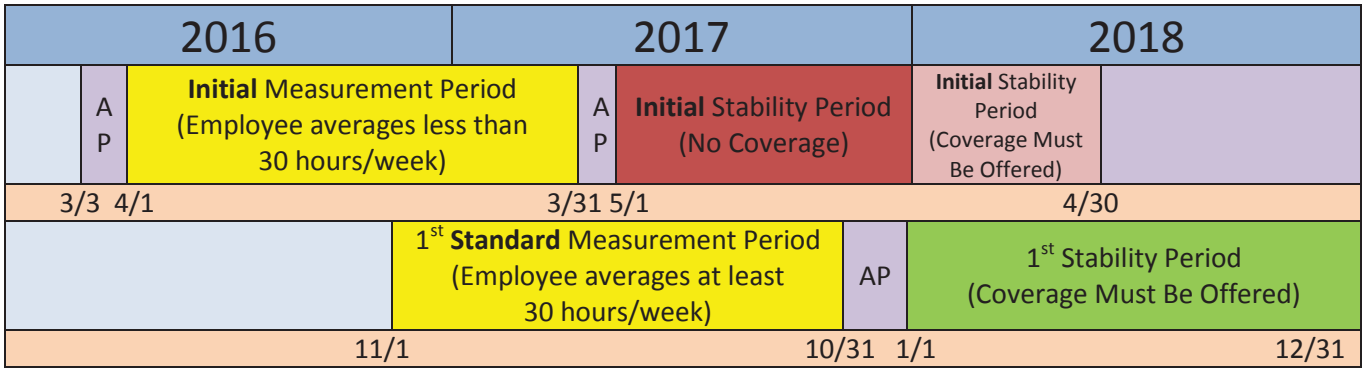
If, on the other hand, the New Employee *did not* average at least 30 hours per week during the Initial Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows the Initial Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Initial Stability Period.

At the same time that a New Employee's hours are being tracked in the Initial Measurement Period, they are also being tracked in the Standard Measurement Period that is applicable to Ongoing Employees. In other words, once a New Employee has been employed for an entire Standard Measurement Period, the (now formerly) New Employee must also be tested for full-time status using the Standard Measurement Period applicable to all other Ongoing Employees. In other words, there will be dual, overlapping measurement periods. Moreover, during this transition from New

Employee to Ongoing Employee, the employee must be given the "best of either" treatment. That is, if one test causes the employee to be considered "full-time," while the other test does not, the "full-time" result must be followed.

To see what these rules look like in a visual format, consider the following example, which is detailed on the chart below. The plan is a calendar year plan. A New Employee is hired on March 3, 2016. During this New Employee's Initial Measurement Period (which runs from April 1, 2016 through March 31, 2017), he/she averages less than 30 hours per week. Accordingly, the Employer normally would be able to exclude the New Employee from coverage during the entire Initial Stability Period (which runs from May 1, 2017 through April 30, 2018). But in our example, assume that this employee does average at least 30 hours per week during the Standard Measurement Period that runs from November 1, 2016 through October 31, 2017. As a result, the employee must be offered coverage during the Stability Period that is associated with that Standard Measurement Period. That Stability Period, which overlaps with the plan year, runs from January 1, 2018 through December 31, 2018. So, even though the Initial Stability Period runs through April 30, 2018, the employee must be offered coverage no later than January 1, 2018, which is the beginning of the Stability Period that is associated with the Standard Measurement Period in which the employee averaged at least 30 hours per week.

The following chart provides a visual of the preceding example:



There are special rules that apply to employees who have employment status changes (e.g., from variable hour to full-time) during their Initial Measurement Period. There are also special rules that apply to employees who are terminated and later rehired. A description of those special rules, however, is simply not possible in this very brief summary.

We recognize that these eligibility rules are incredibly complex. There is no easy way to summarize all the intricate rules and exceptions in a brief 2-3 page summary. If you have questions, we encourage you to contact the Plan Administrator.