Dear **JUDY VETRANO**:

Thank you for choosing Aflac as your supplemental insurance carrier. We appreciate your business.

Enclosed is a packet containing the documents necessary to establish a cafeteria plan. Please carefully review the Flexible Benefits Plan Document and Summary Plan Description (SPD), and verify that all of the information about benefits offered, eligibility, plan administration, and funding is correct for the plan that you will be administering.

The Flexible Benefits Plan itself is not intended to be an ERISA plan required to have an ERISA summary plan description (SPD) even though many of the underlying benefits will be subject to ERISA and required to have their own SPDs. Nonetheless, we refer to the Flexible Benefits Plan summary as an SPD for ease of reference. Please notice that the sample Flexible Benefits Plan Document refers to the Summary Plan Description with regard to many of the plan's provisions. This approach eases administration and reduces the risk of inconsistency between the Flexible Benefits Plan Document provisions and the Summary Plan Description provisions. You should also note that these documents are only sample documents typical of a plan intended to qualify as a Section 125 Cafeteria Plan with the terms and conditions thereof, and that they may need to be modified to conform to your individual circumstances.

Aflac has developed these sample documents with legal counsel, and it is Aflac's intent and belief that the documents in form satisfy the requirements of IRS Code Section 125. However, Aflac is not in the business of offering legal counsel or tax advice, and thus, Aflac cannot and does not make any representations about the legal or tax effect of plans adopted based on the sample provisions in these documents upon any particular employer. Therefore, it is each employer's responsibility to determine, with the assistance of the employer's own legal counsel, the suitability of these particular documents, and the legal and tax effect of these plan documents upon the employer and its employees.

Since Aflac has no control over your subsequent modification and/or administration of the plan and since the Internal Revenue Service will not render an opinion as to a plan's qualified status under IRS Code Section 125, Aflac makes no representation (express or implied) as to your plan's qualification under IRS Code Section 125 and related provisions as adopted and subsequently amended by you.

You, as sponsoring employer, bear sole responsibility for amending your plan (as necessary) to comply with existing tax law and future changes, for meeting all reporting and disclosure requirements imposed by applicable law, and for the daily administration of your plan. As such, we recommend you review the following important information:

Important Compliance Issues

Nondiscrimination Testing. Failure to satisfy these requirements will cause adverse tax consequences to highly compensated and/or key employees and could possibly disqualify the plan.

Qualified Premiums. Certain insurance premiums that cover the employee (or in the case of accident or health coverage other than life insurance, the employee and tax dependents/family) may be included in the Flexible Benefits Plan Documents if adopted as part of your benefits plan. These include the following:

- Group Term Life Insurance covering the employee (eligible under IRS Code Section 79) that is equal to or less than $50,000 (Life insurance coverage on dependents is not eligible for pre-tax treatment.)
- Accidental-Death and Dismemberment (AD&D) coverage
- Group or individual dental, hospital indemnity, cancer insurance, vision, hearing, and other qualified accident and health premiums
- Group (but not individual) major medical coverage.

Effects on taxes. When including health, medical, and disability income policies within the Flexible Benefits Plan, paying for coverage on a pre-tax basis may cause certain insurance benefit payments to be subject to federal and state taxes. Accident benefits will generally be tax free. Disability benefits will be taxable if the employer paid all or part of the premium or if employees funded the coverage on a pre-tax (salary reduction) basis through the cafeteria plan. With regard to supplemental health benefits, when the premium amounts are paid on a pre-tax basis (i.e., employer paid or employee pre-tax salary reduction) benefits are excludable to the extent of unreimbursed medical care expenses. However, benefit payments (combining supplemental cash indemnity benefits as well as the total of actual medical reimbursement benefits from health and medical policies/plans) that exceed the amount of unreimbursed medical expenses would be taxable.

Continuation of Coverage. Health benefits offered through a cafeteria plan may be subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Contact your COBRA administrator for more details.

Continuation of Coverage During FMLA Leave. Health benefits (including health FSA benefits) offered through a cafeteria plan are subject to the continuation provisions, and other all benefits may be subject to the reinstatement provisions of the Family and Medical Leave Act of 1993 ("FMLA"). See Question 13 of the SPD for more details on coverage offered under the Plan during FMLA leave.

HIPAA Privacy and Security Requirements. During the course of providing participants with health coverage under a health FSA (if applicable), the plan will have access to information about covered individuals that is deemed to be protected health information (PHI) by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the Flexible Benefits Plan itself is not a health plan, HIPAA Privacy and Security Rules apply to health plans that you may offer through the Flexible Benefits Plan, including health FSAs. The employer is solely responsible for ensuring that the employer and the plan comply with HIPAA's rules. If you are a Health FSA plan sponsor, Aflac is enclosing a privacy packet (Important Privacy Information) with an overview of the HIPAA Privacy Rules. Aflac is also including general HIPAA language in the sample documentation (Section 10.18 of the Flexible Benefits Plan Document and, for full plans only, Appendix II to the SPD). The privacy information provided in this cafeteria plan packet is not provided with the intent of fully satisfying your HIPAA obligations. HIPAA's Privacy Rules are complicated, and their effects may vary for each plan. Please consult with your legal counsel regarding your required actions and plan language for your company and plan to achieve HIPAA compliance.

Plan Administration and Maintenance

Plan Document Maintenance. Each plan sponsor is responsible for reviewing the sample Flexible Benefits Plan Documents and adopting a plan that is consistent with the desired plan design and any legal requirements that may apply in your state. For your added convenience and your future reference, the most current version of the sample cafeteria plan packet will be available on the Aflac Web site (aflac.com). The sample cafeteria plan documents will be updated periodically to correspond with changes in applicable laws.

Summary Plan Description. All URM FSA plan sponsors are required to give each eligible employee a copy of the SPD within 120 days of the effective date of the initial plan year and within 90 days of the effective date of coverage for all subsequent plan years. If an employer makes a change in the plan, the employer must provide employees with a summary of the changes [a Summary of Material Modifications (SMM)] within 60 days of the adoption of the change. **Note:** While the plan and related documents are copyrighted, Aflac gives you limited permission to copy the documents as necessary for distribution to your employees for use solely in the operation of your own cafeteria plan.

Payroll Instructions. Payroll instructions will be thoroughly reviewed with you or your payroll representative by your Aflac agent.

Employee Eligibility and Elections

New Employees. For details regarding employee eligibility, please refer to Section 2.01 of the Flexible Benefits Plan Document.

Special Rule for URM Eligibility. Current tax rules require that the URM be extended solely to employees who are eligible for major medical coverage that you offer.

Employees of Affiliated Companies. If the requirements of IRS Code Section 414(b), (c), (m), or (o) are satisfied, the employees of an affiliated company may be able to participate in this plan. Please consult with your tax advisor concerning the potential impact of IRS Code Section 414(b), (c), (m), and (o).

Benefit Election Changes. Employees generally cannot change their election to participate in the pre-tax contribution payment option or vary the pre-tax contributions they have selected. For details regarding important exceptions to this general rule, please refer to Section 3.04 of the Plan Document and Question 9 of the SPD.

Due to the complexity of cafeteria plans, we recommend that you consult with your accountant, attorney or other tax advisor concerning the plan provisions, administration, and operation before executing the Plan Documents. Remember that your cafeteria plan will not be effective until your plan is adopted. **NOTE: The Flexible Benefits Plan Documents you adopt must be signed PRIOR TO THE EFFECTIVE DATE.** If your Flexible Benefits Plan Document is executed after the effective date, the IRS may attempt to challenge the qualified status of your plan. We recommend that you retain any evidence that you have showing that your plan was adopted and that enrollments were completed prior to the effective date. If no pre-tax deductions have been made thus far, you may consider changing the start date of your cafeteria plan.

Aflac will use its best efforts to provide employers with information from time to time about developments concerning Section 125 Cafeteria Plans. However, for reasons stated above, it is the employer's responsibility to maintain the qualified status of the Section 125 Cafeteria Plan in form and in operation.

We value the trust you have placed in us. If you need our help or if you have any questions, please call us toll-free at 1-800-992-3522. Our customer service representatives are here to assist you Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Sincerely,

Aflac New Account Setup Department

Enc.

FLEXIBLE BENEFITS PLAN ACCOUNT ESTABLISHMENT INFORMATION AND CHECKLIST

Important steps for establishing your Flexible Benefits cafeteria plan

➢ **For all Flex One Cafeteria Plans:**

☐ **Employer's Acknowledgment:** After executing and adopting your Plan Document, please sign and date the Employer's Acknowledgment in order to officially adopt and execute your plan. Place the signed and dated Employer's Acknowledgment in your files with a copy of your Plan Document Packet.

☐ **Summary Plan Description:** A copy must be provided to each eligible employee as soon as possible (prior to enrollment is preferred).

Important information for administering your cafeteria plan

☐ **Plan Identification Number (PIN):** The Department of Labor regulations require that welfare benefit plan sponsors assign a three-digit PIN number to their welfare plans (including URMs offered through cafeteria plans) for identification purposes. Numbering for welfare plans should begin at 501 and proceed consecutively. If you have other plans (e.g., health coverage) assign the next open number. This number must be indicated on the Summary Plan Description.

☐ **Affiliated Companies:** Only those companies described in Section 414(b), (c) or (m) of the Internal Revenue Code can participate in a cafeteria plan. In addition, if there are affiliated companies, nondiscrimination testing may be affected by affiliated companies. Consult your tax advisor.

☐ **5500 and Summary Annual Report:** While there is no Form 5500 filing requirement for the cafeteria plan itself, welfare benefit plans subject to ERISA, which may include URM flexible spending accounts (FSAs), must file Form 5500 and any applicable schedules (unless an applicable exception applies) - even if the benefits are funded through the cafeteria plan. You should contact your tax or legal advisor to find out if your Plan is subject to ERISA and whether filing a Form 5500 (including any applicable schedules) for your Plan is required.

☐ **Nondiscrimination Testing:** Tax nondiscrimination tests, including the Eligibility, Contributions and Benefits, and Concentration of Benefits tests, must be performed. In the case of Flexible Spending Accounts (FSAs), nondiscrimination tests must be performed for each FSA.

☐ **Health FSAs (URM):** You, as Plan Sponsor, are responsible for ensuring that the URM FSA maximum, is in line with your risk tolerance. Remember, IRS Notice 2005-42 allows an additional 2 ½ month period (i.e., grace period) in which to incur additional medical expenses, and IRS Notice 2013-71 allows a carryover option of up to $500 unused health FSA funds. The grace period option and carry over option cannot be offered simultaneously. If you have selected either the grace period feature or the carry over feature, the Aflac sample plan incorporates language for either option. Also, remember that participant salary reductions are subject to dollar limitations set forth by the IRS which may be adjusted annually.

☐ **Eligibility:** Any eligibility waiting period for pre-tax benefits should generally be uniformly applied. You, as Plan Sponsor, are responsible for ensuring that the eligibility period listed in your plan documents does not violate Internal Revenue Service or Department of Labor regulations.

☐ **Privacy:** You, as Plan Sponsor, are responsible for ensuring that your plan does not violate the privacy requirements set forth in the Gramm-Leach-Bliley Act of 1999 (GLB) and, if applicable, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and the Final HIPAA Omnibus Rule. GLB regulates the privacy of financial information and applies to all Flexible Benefit plans (see the attached “Privacy Practices”). HIPAA protects privacy by regulating the disclosure of protected health information (PHI), so Plan Sponsors of only health FSAs must comply with HIPAA privacy requirements (health FSA Plan Sponsors only, see the attached “Important Privacy Information”).

☐ **HSA Documentation:** The sample Flexible Benefits Plan document includes language to enable pre-tax contributions for health savings accounts (HSAs). Any HSA will require additional documentation that must be arranged through an HSA trustee or custodian. Aflac does not serve as an HSA custodian or trustee, and does not provide such documentation.

*** If you have any questions regarding this checklist, please contact Aflac toll-free at (1-800-992-3522), and one of our Customer Service Representatives can assist you Monday through Friday from 8:00 A.M. to 7:00 P.M. EST.**

Employer Acknowledgment: Your signature verifies that an Aflac sales representative has reviewed the above information with you.

Signature	Printed Name	Date

PRIVACY PRACTICES

Protecting the privacy and confidentiality of employer and participant information through our Flexible Benefits cafeteria plan is very important to American Family Life Assurance Company of Columbus (Aflac) and American Family Life Assurance Company of New York (Aflac New York). Throughout this notice when we use the name "Aflac," we will be referring to both organizations. Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information about employers or employees of an employer for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.

- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of the employer and employees of the employer are properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.

- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that its employees and agents carry out these practices and otherwise protect the personal information of our customers. Both employees and agents are subject to censure, dismissal or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

PRIVACY NOTICE

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

Collection of Information

As part of Aflac's normal operating procedures, Aflac (and our agents acting on our behalf) needs to obtain information from both the employer and the participant to determine an individual's eligibility for our products and services, and to perform our insurance functions. Aflac and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac customers, including but not limited to:

- Information from the employer or the participant (including names, addresses, Social Security numbers, financial and marital status, and health and dependent child-care information);

- Information about the employer or the participants' transactions with Aflac or our agents (including claims, payment information and banking information);

- Information from the employer or the participants' health care providers (including drug receipts and medical information), employers (including benefit elections and employment information) and family members and Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information) and family members.

Disclosure of Information

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your policy coverage, election amounts, premiums and payment history) to our agents or other third parties who perform services or functions on our behalf, including the marketing of Aflac services. Aflac may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of the employer or the participants' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make. Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about our customers for any purpose other than disclosures for the performance of insurance functions by Aflac or on our behalf, disclosures that are permitted or required by law, or to which the customer consents.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

Confidentiality and Security

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive, or maintain about Aflac's customers. Aflac maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our customer information and records; to protect against anticipated threats or hazards to such records; and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

NOTICE OF INFORMATION PRACTICES

Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: Aflac may obtain information about you and any other persons proposed for insurance. Some of this information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to: Aflac Worldwide Headquarters, ATTN: Client Services, 1932 Wynnton Road, Columbus, Georgia 31999.

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

If you would like a copy of Aflac's Notice of Privacy Practices - Protected Health Information, issued pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by sending a written request to: Aflac Worldwide Headquarters, ATTN: Privacy Office, 1932 Wynnton Road, Columbus, Georgia 31999.

TABLE OF CONTENTS
FLEXIBLE BENEFITS PLAN

PREAMBLE 3

ARTICLE I - DEFINITIONS 3
1.01 "Affiliated Employer" 3
1.02 "After-tax Contribution(s) " 3
1.03 "Anniversary Date" 3
1.04 "Benefit Plan(s) or Policy(ies) " 3
1.05 "Board of Directors" 3
1.06 "Change in Status" 3
1.07 "Code" 3
1.08 "Compensation" 3
1.09 "Dependent" 3
1.10 "Dependent Care Expense Reimbursement" 3
1.11 "Earned Income" 3
1.12 "Effective Date" 3
1.13 "Eligible Employment-Related Expenses" 3
1.14 "Eligible Medical Expenses" 4
1.15 "Employee" 4
1.16 "Employer" 4
1.17 "ERISA" 4
1.18 "Medicare Care Expense Reimbursements" 4
1.19 "Highly Compensated Individual" 4
1.20 "Key Employee" 4
1.21 "Nonelective Contribution(s)" 4
1.22 "Participant" 4
1.23 "Plan" 4
1.24 "Plan Administrator" 4
1.25 "Plan Year" 4
1.26 "Premium Deduction Authorization" or "PDA" 4
1.27 "Pre-tax Contribution(s)" 5
1.28 "Qualified Benefit" 5
1.29 "Qualifying Employment-Related Expenses" 5
1.30 "Qualifying Individual" 5
1.31 "Qualifying Services" 5
1.32 "Reimbursement Account(s)" or "Account(s)" 5
1.33 "Spouse" 5
1.34 "Student" 5
1.35 "Summary Plan Description" or "SPD" 5
1.36 "Trustee" 5

ARTICLE II - ELIGIBILITY AND PARTICIPATION 5
2.01 Eligibility to Participate 5
2.02 Termination of Participation 6
2.03 Eligibility to Participate in Reimbursement Accounts 6
2.04 Qualifying Leave Under FMLA 6
2.05 Non-FMLA Leave 6

ARTICLE III - BENEFIT ELECTIONS 6
3.01 Election of Contributions 6
3.02 Initial Election Period 6
3.03 Annual Election Period 6
3.04 Change of Elections 6
3.05 Impact of Termination of Employment on Election or Cessation of Eligibility 7

ARTICLE IV - BENEFIT FUNDING AND CREDITS AND DEBITS TO ACCOUNTS 7
4.01 Source of Benefit Funding 7
4.02 Reduction of Certain Elections to Prevent Discrimination 7
4.03 Medical Care Expense Reimbursement 7
4.04 Dependent Care Expense Reimbursement 7

ARTICLE V - BENEFITS 8
5.01 Qualified Benefits 8
5.02 Cash Benefit 8
5.03 Repayment of Excess Reimbursements 8
5.04 Termination of Reimbursement Accounts 8
5.05 Coordination of Benefits Under the URM 8

ARTICLE VI - PLAN ADMINISTRATION 8
6.01 Allocation of Authority 8
6.02 Payment of Administrative Expenses 9
6.03 Reporting and Disclosure Obligations 9
6.04 Indemnification 9
6.05 Substantiation of Expenses 9
6.06 Reimbursement 9
6.07 Annual Statements 9

ARTICLE VII - FUNDING AGENT 9

ARTICLE VIII - CLAIMS PROCEDURES 9

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN 10
9.01 Permanency 10
9.02 Employer's Right to Amend 10
9.03 Employer's Right to Terminate 10
9.04 Determination of Effective Date of Amendment or Termination 10

ARTICLE X - GENERAL PROVISIONS 10
10.01 Not an Employment Contract 10
10.02 Applicable Laws 10
10.03 Post-Mortem Payments 10
10.04 Nonalienation of Benefits 10
10.05 Mental or Physical Incompetency 10
10.06 Inability to Locate Payee 10
10.07 Requirement for Proper Forms 10
10.08 Source of Payments 10
10.09 Multiple Functions 11
10.10 Tax Effects 11
10.11 Gender and Number 11
10.12 Headings 11
10.13 Incorporation by Reference 11
10.14 Severability 11
10.15 Effect of Mistake 11
10.16 Provisions Relating to Insurers 11
10.17 Forfeiture of Unclaimed Reimbursement Account Benefits 11
10.18 HIPAA Privacy 11

ARTICLE XI - CONTINUATION COVERAGE UNDER COBRA 11

EMPLOYER'S ACKNOWLEDGEMENT 12

ATTACHMENT I - SUMMARY PLAN DESCRIPTION (SPD)

PREAMBLE

The Employer hereby establishes a Flexible Benefits Plan ("Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125. The Dependent Care Expense Reimbursement Plan ("DDC") is intended to qualify as a Code Section 129 dependent care assistance plan, and the Medical Care Expense Reimbursement Plan ("URM") is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the DDC and URM Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA. The DDC and the URM are available only if designated as a Benefit Plan or Policy in the Summary Plan Description (SPD).

FLEXIBLE BENEFITS PLAN

ARTICLE I - DEFINITIONS

1.01 **"Affiliated Employer"** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m) of the Code.

1.02 **"After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization (PDA) after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan.

1.03 **"Anniversary Date"** means the first day of any Plan Year.

1.04 **"Benefit Plan(s) or Policy(ies)"** means those Qualified Benefits available to a Participant under this Plan as set forth in the SPD, as amended and/or restated from time to time.

1.05 **"Board of Directors"** means the Board of Directors or other governing body of the Employer (the "Board"). The Board, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.06 **"Change in Status"** means any of the events described in the SPD, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the SPD for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.07 **"Code"** means the Internal Revenue Code of 1986, as amended.

1.08 **"Compensation"** means the cash wages or salary paid to an Employee by the Employer.

1.09 **"Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a) except as otherwise set forth in Code Section 21 (for Dependent Care FSA purposes, if offered under the Plan), Code Section 105 (for health plan purposes, if offered under the Plan), and Code Section 223 (for Health Savings Account purposes, if offered under the Plan). Also, for DDC purposes, a Dependent shall also be defined as in Code section 21(e)(5) (i.e., dependent of the custodial parent as defined in Code Section 152(e)). Children, as defined in Code Section 152(f)(1), are considered Dependents until age 26 (regardless of residence, marital status, tax dependent status, student status, or other factors).

1.10 **"Dependent Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.11 **"Earned Income"** means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includable in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.12 **"Effective Date"** of this Plan is the effective date set forth in the SPD.

1.13 **"Eligible Employment-Related Expenses"** means those Qualifying Employment-Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the DDC and during the Plan Year (plus any applicable grace period extension as described in the SPD), other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.14 **"Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the URM and during the Plan Year (plus any applicable grace period extension or carryover option as described in the SPD) to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): i) expenses for qualified long term care services (as defined in Code § 7702B(c)); and ii) expenses incurred for health insurance premiums; and iii) over-the-counter drugs and medicines that are not prescribed by a physician. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.15 **"Employee"** means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n)) or any self- employed individual who receives from the Employer "net earnings from self-employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee.

1.16 **"Employer"** means the Employer and the Affiliated Employers named in the SPD provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only that entity named on the first line of the Plan Information Summary of the SPD, and not any Affiliated Employer. Affiliated Employers who sign the Plan Information Summary and/or otherwise adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.17 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.18 **"Health Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.19 **"Highly Compensated Individual"** means an individual defined under Code Section 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.20 **"Key Employee"** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.21 **"Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefit Plan(s) or Policy(ies) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Plans or Policies offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

1.22 **"Participant"** means an Employee who becomes a Participant pursuant to Article II.

1.23 **"Plan"** means the Flexible Benefits Plan, the SPD (defined in Section 1.35 herein) and (if applicable) the related Trust created by this document.

1.24 **"Plan Administrator"** means the person(s) or Committee identified in the SPD that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.25 **"Plan Year"** shall be the period of coverage set forth in the SPD (as extended by any applicable grace period as set forth in the SPD).

1.26 **"Premium Deduction Authorization" or "PDA"** Means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Plans or Policies with Pre-tax or

After-tax contributions and/or Benefit Credits (if offered under the plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the PDA may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.27 **"Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan or Policy afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.28 **"Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, benefits prohibited under Section 125(f) (e.g. qualified health plans (as defined in Section 1301 of the Affordable CareAct) that are purchased in the individual market through a public Exchange and long-term care insurance) are not "Qualified Benefits".

1.29 **"Qualifying Employment-Related Expenses"** means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.30 **"Qualifying Individual"** means an individual defined as a “Qualifying Individual” in the Summary Plan Description.

1.31 **"Qualifying Services"** means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.32 **"Reimbursement Account(s)” or “Account(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) and Dependent Care Reimbursement (as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the SPD. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.33 **"Spouse"** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.34 **"Student"** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

1.35 **"Summary Plan Description" or "SPD"** means the document attached as Attachment I to the Plan document that describes the term of Plan not set forth herein. The SPD and all applicable appendices are incorporated hereto by reference.

1.36 **"Trustee"** (if applicable) means the person(s) or institution (and their successors) named on the signature page attached hereto, who have assented to being so named by their signature to this Agreement, otherwise empowered to hold and disburse the funds that are created hereunder.

ARTICLE II - ELIGIBILITY AND PARTICIPATION

2.01 **Eligibility to Participate.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of any applicable entry date set forth in the SPD. The provisions of this Article are not

intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Plans or Policies and the terms of eligibility and participation for the Benefit Plan(s) or Policy(ies) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Plans or Policies.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 Eligibility to Participate in Reimbursement Accounts. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the date set forth in the SPD. Participation in the Reimbursement Accounts shall be effective on the date set forth in the SPD.

2.04 Qualifying Leave Under FMLA. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plans or Policies that provide health coverage (including URM benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III - BENEFIT ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Plan or Policy available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plans or Policies offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Nonelective Contributions among the various Benefit Plans or Policies in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date should complete, sign and file a PDA with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial PDA shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date should complete, sign and file a PDA with the Plan Administrator (or its designated third party administrator as set forth on the PDA) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plans or Policies will be effective in accordance with the governing provisions of such Benefit Plans or Policies.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a PDA in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date that the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except for election changes permitted under this Section 3.04, and for changes made during the Annual Election Period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later. The circumstances under which a Participant may change his election under this Plan are set forth in the SPD.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Pre-tax Contributions. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD.

ARTICLE IV - BENEFIT FUNDING

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Plans or Policies shall be funded by the Participant's Pre-tax and/or After-tax Contributions and/or any Nonelective Contributions provided by the Employer. The required contributions for each of the Benefit Plans or Policies offered under the Plan shall be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the PDA) shall equal the contributions required from the Participant less any available Nonelective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus any Nonelective Contributions made available by the Employer for Benefit Plan(s) or Policy(ies) offered under this Plan shall not exceed the aggregate cost of the Benefit Plan(s) or Policy(ies) elected by the Employee.

4.02 Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

4.03 Health Care Reimbursement. To the extent offered under the Plan, each Participant's URM will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the PDA as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the participant for Expenses incurred during the Plan Year (plus any grace period or carryover option as set forth in the SPD) shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his URM. In no event will the amount of Health Care Reimbursements in any Plan Year (plus any grace period, if applicable, as set forth in the SPD) exceed the annual amount specified for the Plan Year in the PDA for Health Care Reimbursement. Unless the Plan provides for the carry-over option of up to $500 of unused health FSA funds, any amount in excess of the pre-determined carry-over limit credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the grace period (if applicable) and Run-Off period set forth in the SPD. The Plan cannot simultaneously provide for both the grace period option and the carryover option. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor (“DOL”) or Internal Revenue Service (“IRS”) regulations. The maximum annual reimbursement under the URM shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD. In no event will Participants’ PDAs include contributions that exceed the dollar limitations set forth by the IRS.

4.04 Dependent Care Reimbursement. To the extent offered under the Plan, each Participant's DDC will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the Run-Off period set forth in the

SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall not exceed the dollar limitations set forth by the IRS.

ARTICLE V - BENEFITS

5.01 Qualified Benefits. The maximum benefit a participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Benefit Plan(s) or Policy(ies) set forth in the SPD (other than Health and DDC); ii) any pre-tax HSA contributions (if allowed under the Plan); and iii) the maximum annual Health Care Reimbursement under the URM as set forth in the SPD (if offered under the Plan); and iv) the maximum annual Dependent Care Reimbursement under the DDC as set forth in the SPD (if offered under the Plan.)

(a) **Special Rules for Health Care Reimbursement**. To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Spouse or Dependents while he is a Participant during the Plan Year (plus any grace period extension as specified in the SPD) for which the Participant's election is effective provided that the substantiation requirements of Section 6.05 herein are satisfied.

(b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year (plus any applicable grace period extension as described in the SPD) for which the Participant's election is effective, provided that the substantiation requirements of Section 6.05 have been satisfied.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.05 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Accounts. Coverage under the URM and/or DDC shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims under the DDC for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until the end of the Run-Off period set forth in the SPD. Participants in the URM may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run-Off period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04.

5.05 Coordination of Benefits Under the URM. The URM is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI - PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Plan or Policy, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer or insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, and data and other documents as may be necessary for the proper administration of the Plan; and

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Payment of Administrative Expenses. Except as otherwise provided in the SPD, the Employer currently pays all reasonable expenses incurred in administering the Plan.

6.03 Reporting and Disclosure Obligations. Unless specified otherwise, it shall be the Employer and Plan Administrator's sole responsibility to comply with all filing, reporting, and disclosure requirements, imposed by the DOL and/or IRS, specifically including, but not limited to creating, filing and distributing Summary Annual Reports, Form 5500s, and SPDs. Furthermore, the Employer and Plan Administrator shall be required to amend the Plan as is necessary to ensure compliance with applicable tax and other laws and regulations.

6.04 Indemnification. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

6.05 Substantiation of Expenses. Each Participant must submit a written Claim Form to the Plan Administrator identified in the SPD or its designated plan service provider to receive reimbursements from the URM and/or DDC, on a form provided by the Plan Administrator accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence, as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

6.06 Reimbursement. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator identified in the SPD or its designated plan service provider. Reimbursements of less than $15 may be carried forward and aggregated with future reimbursements until the reimbursable amount is greater than $15. However, claims for reimbursements outstanding at the end of the Plan Year (plus any grace period as set forth in the SPD) shall be reimbursed without regard to the $15 threshold limit. Year-end expense reimbursements must be submitted to the Plan Administrator within 90 days of the close of the Plan Year for which the PDA is effective, and during which such expense was incurred, in order to be eligible for reimbursement.

6.07 Annual Statements. The Plan Administrator shall furnish each Participant with an annual statement, showing the amounts paid or expenses incurred by the Employer in providing Medical and/or Dependent Care Expense Reimbursement during the previous calendar year and the respective Reimbursement Account balance(s) on or before January 31 following the close of the applicable Plan Year.

ARTICLE VII - FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to PDAs, and/or Nonelective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the DOL taking into consideration any enforcement procedures adopted by the DOL. If a Trust is designated Funding Agent in the SPD, an appropriate Trust Agreement shall be attached at the end of this Plan.

ARTICLE VIII - CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility

and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03 and 4.04 herein.

ARTICLE X - GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

10.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Nonalienation of Benefits. Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

10.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer, the Trust fund (if selected as Funding Agent), and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon

termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 Tax Effects. Neither the Employer, its agents, the Plan Administrator, nor the Trustee makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

10.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 Incorporation by Reference. Except for the Medical and Dependent Care Expense Reimbursement Plan(s), the actual terms and conditions of the separate component Benefit Plans or Policies offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. The provisions of the Medical and Dependent Care Expense Reimbursement Plan(s) are reproduced herein, but shall constitute separate plans for purposes of all applicable Code and ERISA provisions.

10.14 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

10.15 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

10.16 Provisions Relating to Insurers. No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract with this Plan. The insurer shall not be deemed to be a party to this Plan, nor shall it be bound to interpret the construction or validity of the Plan. The insurer shall be protected from its good faith reliance on the written representations and instructions of the Trustee and the Plan Administrator, and shall not be responsible for the initial or continued qualified status of the Plan.

10.17 Forfeiture of Unclaimed Reimbursement Account Benefits. Unless the Employer has implemented a $500 carryover with respect to the URM, any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

10.18 HIPAA Privacy. To the extent a URM is offered under the Plan, the rights and obligations of an individual covered under the URM, the Employer and Plan, with respect to permitted uses and disclosures of a covered individual's protected health information, set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be summarized in the SPD.

ARTICLE XI - CONTINUATION COVERAGE UNDER COBRA

The SPD includes provisions that shall be applicable to the URM to the extent the URM is a “group health plan” as defined by Code §§ 4980B and 5000(b)(1) and the regulations promulgated thereunder and to the extent it is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA.

IN WITNESS WHEREOF, the Employer has executed this Plan as of the date set forth below.

EMPLOYER'S ACKNOWLEDGMENT

As evidenced by the formal execution of this document, the undersigned Employer adopted and established this Plan on the Effective Date as the Flexible Benefits Plan of the undersigned Employer. In doing so, the undersigned Employer acknowledges that the Summary Plan Description ("SPD") and this Plan document are important legal instruments with significant legal and tax implications.

The Employer also acknowledges that it has read this SPD and the Plan document in their entirety, has consulted independent legal and tax counsel other than representatives of American Family Life Assurance Company of Columbus (Aflac), to the extent considered necessary, and accepts full responsibility for participation of Employees hereunder and the operation of the Plan. The Employer acknowledges that, as sponsor and Plan Administrator, it shall have sole responsibility to comply with all filing, reporting, and disclosure requirements imposed by the DOL, IRS, or any other government agency, specifically including, but not limited to, creating and filing Form 5500s and preparing and distributing SPDs and performing required nondiscrimination testing.

Furthermore, the Employer further acknowledges that it shall bear sole responsibility for amending the Plan as necessary to ensure compliance with applicable tax, labor, and other laws and regulations. The Employer acknowledges receipt of the checklist of Plan Sponsor Responsibilities included provided with the applicable plan document request form and has agreed to the obligations set forth therein.

It is also understood and agreed that American Family Life Assurance Company of Columbus (Aflac), and its subsidiaries, agents, and representatives, are not providing legal or tax advice to the undersigned Employer in connection with this Plan and that no representations are made by it with respect to the operation of the Flexible Benefits Plan pursuant to the documents provided by American Family Life Assurance Company of Columbus (Aflac) to the Employer.

This Plan shall be construed and enforced according to the Internal Revenue Code of 1986, as amended from time to time, the applicable regulations thereto, and the laws of the state of the principal place of business of the Employer.

IN WITNESS WHEREOF, the Employer has caused this Plan and Summary Plan Description to be executed on the day of _____,_____ to ratify the adoption of the Plan adopted and effective as of the Effective Date.

WITNESS:

Employer: _____

By: _____

Title: _____

Date: _____

_____

Corporate Officer

ATTACHMENT I - SUMMARY PLAN DESCRIPTION

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN
EMPLOYER INFORMATION

1) Name and Address of Employer: **CROTON HARMON UFSD**

   Plan Administrator: **JUDY VETRANO**
   10 GERSTEIN ST
   CROTON ON HUDSON, NY 10520

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number: **(914) 271-4713**
3) Employer's Federal Tax Identification Number: **13-6007110**
4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned): _____
5) 125 Start Date: **01/01/01**
6) Effective Date of this Plan: **01/01/12**
7) Last Day of the Plan Year: **12/31/12**
   Subsequent Plan Years: **01/01-12/31**
8) Name and Address of FSA Claim Administrator: **CLAIMS PROCESSOR: FLEX ONE**
   1932 WYNNTON ROAD
   COLUMBUS, GA 31999
9) Name and Address of registered agent for service of legal process: **JUDY VETRANO**

10) Affiliated Employers that will participate in the Plan :

11) Employer's Type of Business: **CORPORATION**

ELIGIBILITY
All Employees employed by the Employer shall be eligible to participate under the Plan except the following: **PT, THOSE UNIONS WHO HAVE NOT YET NEGOTI.THE BENEF**

An eligible Employee may become a Participant in the Plan:

[ ] Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).

[ ] On the **day** following commencement of employment.

[**X**] On the first day of the month following **1** days of employment.

[ ] Other: **OTHER**
provided the Employee completes a Premium Deduction Authorization ("PDA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contributions shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

[ ] On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.

[ ] On the day following commencement of employment.

[ ] On the first day of the month following days of employment.

[ ] Other: **OTHER**, provided the Employee completes a PDA selecting such benefits.

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the PDA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

[**X**] Group Major Medical Coverage

[ ] Vision Care Coverage

[**X**] Disability Income - Short Term (A&S)

[**X**] Cancer Insurance

[**X**] Dental Coverage

[**X**] Group Term Life Insurance

[ ] Disability Income - Long Term (LTD)

[ ] Intensive Care Insurance

[**X**] Accident Insurance

[**X**] Hospital Indemnity Insurance (HIP)

[**X**] Specified Health Event

[ ] Personal Sickness Indemnity (PSI)

[**X**] Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed $ **3500** per Plan Year pursuant to the **CROTON HARMON UFSD** Medical Care Expense Reimbursement Plan.

Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable): _____
_____
_____

[**X**] Dependent Care Expense Reimbursement described in Appendix I to this SPD.

[ ] Health Savings Account (as defined in Code Section 223) established with the following

Custodian/Trustee: _____

[ ] Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one):

❑ The Employer, which will comply with the requirements of Article VII of the Plan.

❑ The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

❑ The Employer, except as otherwise noted in the Plan.

❑ The Participants, except as otherwise noted in the Plan.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will **automatically** cease, and you will not be able to make any more

Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by communicating to your employer, prior to the Plan start date, your election to participate in the Plan by signing an individual Premium Deduction authorization (PDA) on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided a PDA when you first become eligible to participate in this Plan.

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file a PDA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting a PDA prior to the beginning of each Plan Year -- no deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	**Without Cafeteria Plan**
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Potential Monthly Savings: $31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the PDA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or

Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

   - a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
   - a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
   - any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
   - an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
   - a change in your, your Spouse's or your Dependent's place of residence.
   - a change in your employment status such that you are no longer to average 30 hours or more per week each month but does not otherwise cause you to lose eligibility for group health benefits that provide minimum essential coverage; or
   - you are eligible to enroll in a Qualified Health Plan offered in the Marketplace during the Marketplace's special or annual enrollment period.

   If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

   As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary)*. With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- *Ability to Procure Minimum Essential Coverage.* For a Change in Status in which you no longer average 30 hours or more per week each month but do not otherwise lose eligibility for group health benefits that provide minimum essential coverage, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

- *Gain of Coverage Eligibility in the Marketplace.* For a Change in Status in which you gain eligibility for coverage in a Qualified Health Plan in the Marketplace's special or annual enrollment period, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Mike is married to Sharon, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under

this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

   Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

   Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

Q-10. How long will the Plan remain in effect?

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

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.

APPENDIX I TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Medical Care and Dependent Care Reimbursement Plan Summary Plan Description

To the extent elected by the Employer (indicated in the Plan Information Summary attached to this SPD), you will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Reimbursement Plan ("URM") and/or some or all of your work-related Dependent care expenses under the Dependent Care Reimbursement Plan ("DDC") (collectively, the "Reimbursement Plans"). Under the URM and DDC, you purchase a specific level of reimbursement benefits and you provide a source of pre-tax funds to reimburse yourself for your Eligible Expenses. For both, you pay for coverage through the Premium Deduction authorization ("PDA") with the Employer, in lieu of receiving a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save Social Security and income taxes on the amount of your salary conversion.

By enrolling in either the URM or DDC option and submitting reimbursement claims you **specifically** authorize the Plan, and its respective agents, employees, sub-contractors, and assigns to use your personal health information in their possession to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation, and to further disclose such information as is reasonably required for those purposes. You further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or for detecting or preventing fraud or misrepresentation. You further waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of administering the Plan (including processing or evaluating a claim for benefits under the Plan) or to detect or prevent fraud or misrepresentation. This authorization does not and is not intended to in any way limit any right the Plan, or its respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

General Questions and Answers

Q-1. Who can participate in the URM and/or DDC?

Each employee who satisfies the eligibility requirements described in the Plan Information Summary is eligible to participate in the Reimbursement Plans as of the eligibility date described in the Plan Information Summary.

Q-2. How do I become a Participant?

You become a Participant by electing URM and/or DDC benefits during the Initial or Annual Enrollment Periods. (The Initial and Annual Enrollment Periods are described in Q-6 of the Flexible Benefits Plan SPD.) Your participation in the URM or DDC will be effective on the date that you make an election to participate or the eligibility date described in the Plan Information Summary, whichever is later. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-9 of the Flexible Benefits Plan SPD. Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the URM, Eligible Dependents are the following:

1. Your legal Spouse (as determined by state law) and

2. Any other individual who would qualify as a tax Dependent under Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order relating to the URM, the URM will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your Health Care Account (See Q-3 below), it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

Q-3. What are my "URM Account" and my "DDC Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing account will be established under each Plan to keep a record of the reimbursements you are entitled to under each Plan, as well as the contributions you have made for such benefits during the Plan Year. No actual accounts are established; they are merely bookkeeping accounts.

Q-4. When does coverage under the URM and/or DDC end?

You continue to participate in the URM and/or DDC until the ealier of (i) you elect not to participate in accordance with Q-9 of Flexible Benefits Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period; (iii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iv) you terminate employment with the employer; or (v) the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You are not eligible to receive reimbursement for otherwise Eligible Medical Expenses incurred during the Plan Year after you cease to be eligible unless you elect COBRA continuation coverage (as described below in Q-18 of this Appendix), provided you are eligible to elect COBRA. However, you will be eligible to receive reimbursement under the DDC for Eligible Employment-Related Expenses (as defined in Q-9 below) incurred during the Plan Year but after you cease to be eligible up to your account balance as of the date you cease to be eligible.

Coverage under the URM for your Eligible Dependents ends on earliest of the following to occur: (i) your coverage ends; (ii) the individual ceases to be an Eligible Dependent (e.g. divorce or legal separation from the spouse); or (iii) the Plan is terminated or amended to exclude individual or the class of individuals of which the individual is a member (spouse or dependent child) from coverage under the URM. Your Spouse and/or your Dependent children may also be entitled to COBRA continuation coverage if coverage is lost for certain reasons. See Q-18 of this Appendix for more information on COBRA.

Q-5. What happens to my URM Account and/or DDC Account if I take an approved leave of absence?

Generally, the rules described in Q-13 of your Flexible Benefits Plan SPD apply. However, if your URM coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the URM at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a URM reimbursement level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your URM coverage was not in effect are not eligible for reimbursement under this URM.

Q-6. What is the maximum URM and/or DDC benefit I may elect?

For URM, you may choose any amount of annual reimbursement you desire subject to the maximum reimbursement amount set forth in the Employer Information Section of the Plan Information Summary. The maximum reimbursement amount is also subject to dollar limitations set forth by the IRS which may be adjusted annually.

For DDC, this is set forth in the Employer Information Section, however, this amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. You may receive the maximum reimbursement amount per Plan Year if you -

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

If you are married and reside together but file a separate federal income tax return, the maximum DDC benefit you may elect will be lowered.

You will be required to pay the annual contribution equal to the coverage level you have chosen.

Q-7. How is my Medical Care and/or Dependent Care Expense Reimbursement benefit paid for and what amounts will be available at any particular time during the Plan Year?

For URM and DDC, when you complete the PDA, you specify the amount of Medical Care and or Dependent Care Expense Reimbursement(s) you wish to pay for with your Pre-tax Contributions. Thereafter, you must make a contribution for such coverage by having an equal portion of the annual reimbursement amount deducted from each paycheck. Your employer will distribute benefit payments from its general assets.

For URM Benefits, the full amount of the coverage you have elected, reduced by the amount of prior reimbursements received during the Plan Year, will be available to reimburse you for your out-of-pocket medical expenses incurred at any time during the Plan Year and while you are a Participant. For DDC Benefits, the amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Account less any reimbursements already paid.

Q-8. How do I receive reimbursement under the Plan?

If you elect to participate in URM or DDC, you will have to take certain steps to be reimbursed for your Eligible Medical and/or Eligible Employment-Related Expenses (as defined in Q-9 below). When you incur an expense that is eligible for payment, you submit a request to the Plan's Administrator on a Request for Reimbursement form that will be supplied to you.

For URM and DDC, you must include written statement(s)/bill(s) from an independent third party(ies) stating that the eligible expenses have been incurred, and the amount of such expense(s) along with the Request for Reimbursement form. In addition, you must include for URM claims an Explanation of Benefits (EOB) form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay.

For DDC, if your reimbursement request is for an amount that is more than your current Account balance, the excess part of the reimbursement will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total Dependent Care expenses above your available, annual credits to your Account.

With respect to either DDC or URM benefits, you may not be reimbursed for any expenses that arise before your PDA becomes effective, or for any expense incurred after the close of the Plan Year (unless the Employer has adopted a grace period).

To have your Request for Reimbursements processed as soon as possible, please read the reimbursement instructions on the back of the Request for Reimbursement form you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Medical and/or Eligible Employment-Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. In addition, you will have 90 days after the end of the Plan Year in which to submit a Request for Reimbursement form for Eligible Expenses incurred during the previous Plan Year (Run-off Period). You will be notified in writing if any Request for Reimbursement is denied.

Q-9. What is an "Eligible Expense?"

For URM, an “Eligible Medical Expense” is generally an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

1. The expense is for “medical care” as defined by Code Section 213(d). Whether an expense is for “medical care” is within the sole discretion of the Plan Administrator;

2. The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines “medical care” as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both over-the-counter drugs (and over-the-counter devices) when accompanied by a physician’s prescription for the over-the-counter drug or medicine (or over-the-counter device). A prescription is defined as an electronic or written order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual authorized to issue a prescription in that state. Not every health related expense you or your eligible dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care”, as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. Also, “stockpiling” of over-the-counter drugs (with a prescription) and/or items, is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute “medical care” as defined by the Code are not reimbursable under the URM per regulations and thus do not constitute an “Eligible Medical Expense” for purposes of the URM:

- Premiums for accident and health insurance or long-term care insurance;

- Over-the-counter drugs and medicines that are not prescribed by a physician: and

- Expenses incurred for qualified long-term care insurance.

For DDC, you may be reimbursed for work-related expenses ("Eligible Employment-Related Expenses") incurred on behalf of any Qualifying Individual described below. Generally, these expenses must meet all of the following conditions for them to be Eligible Employment-Related Expenses:

- The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.

- Services are incurred for a Qualifying Individual. A Qualifying Individual is:

  1. An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g., a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her own support; or

  2. A Spouse or other tax "Dependent" (as defined generally in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" means an individual who is your tax dependent as defined under Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Section 151(d); (ii) the individual is a dependent of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

- The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.

- If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

- If the expenses are incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-10. When must the expenses be incurred?

Eligible Medical and Employment-Related Expenses must generally have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your PDA becomes effective, or for any expenses incurred after the close of the Plan Year (except for expenses incurred during a grace period following the end of the Plan Year, if the Employer has adopted a grace period) or, except for Continuation Coverage and certain Eligible Employment-Related Expenses, after a separation from service. You may be reimbursed for Eligible Employment-Related Expenses that are incurred after a separation from service up to your account balance on the date of separation from service.

In addition, IRS regulations require that service or treatment be actually rendered prior to the time that the expense is reimbursed. Therefore, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (e.g., orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied.

If your Employer has adopted a grace period for the DDC or URM plan then:

- For DDC, if an additional grace period is provided that follows the end of the Plan Year during which amount have been allocated to the DDC that are unused at the end of the Plan Year, then they may be used to reimburse Eligible Employment-Related expenses incurred during the grace period. Unless otherwise specified by your Employer, the grace period will begin on the first day of the Plan Year following the Plan Year to which it relates and will end two (2) months and fifteen (15) days later. For example, if the Plan Year ends December 31, the grace period begins January 1st and ends March 15th.

- For URM, if an additional grace period is provided that follows the end of the Plan Year during which amount have been allocated to the URM that are unused at the end of the Plan Year, then they may be used to reimburse Eligible Medical Expenses incurred during the grace period. The grace period will begin on the first day of the Plan Year following the Plan Year to which it relates and will end two (2) months and fifteen (15) days later. For example, if the Plan Year ends December 31, the grace period begins January 1st and ends March 15th.

- In order to take advantage of the grace period, you must be a participant in the plan on the last day of the Plan Year to which the grace period relates.

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.

- Claims will be paid in the order that they are received.

You may not use URM amounts to reimburse Eligible Employment-Related expenses and DDC amounts may not be used to reimburse Eligible Medical Expenses.

Q-11. What if the Eligible Medical or Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Care and/or Dependent Care Expense Reimbursement?

<u>If your Employer has not adopted a grace period or the carryover option then:</u>

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. This is called the "Use-it-or-Lose-it" Rule. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the ninetieth (90th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

<u>If your Employer has adopted a grace period option, then:</u>

After any eligible grace period expenses have been reimbursed, any remaining amounts will be forfeited to the Employer. (see the paragraph above).

<u>If your Employer has adopted a carryover option for the URM plan then:</u>

The carryover option is only applicable to the URM benefit.

The URM Plan cannot have both a grace period and a carryover option. The Employer must revoke any URM grace period in order to offer the carryover option.

For DDC, you will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. This is called the “Use-It-or-Lose-It” Rule. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the ninetieth (90th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.
For URM, you are not entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred and the annual coverage level you have elected and paid for, unless the Employer has adopted the URM carryover. If the URM carryover has been elected, notwithstanding anything to the contrary in the Summary Plan Description, URM balances that are unused for a Plan Year may be used for reimbursement of eligible URM expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year)—subject to the following terms and conditions:

- No more than $500 of the unused amount for a Plan Year (“Carryover Maximum”) may be rolled over for use in the subsequent Plan Year

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year ("Carryover").

    - For example, if you have an unused URM FSA balance at the end of the 2014 Plan Year equal to $1000, and you have no other expenses that were incurred in 2014, your 2014 Carryover amount that may be used in the 2015 Plan Year is $500. However, if you have 2014 Plan Year expenses equal to $600 that you timely submit during the run out period for the 2014 Plan Year, then your 2014 Carryover amount that may be used in the 2015 Plan Year will only be $400.

- If you incur an eligible expense during a Plan Year ("Current Year Expense") but before the end of the prior Plan Year's run out period, the plan administrator may, at its discretion, apply up to $500 of the amount unused at the end of the prior Plan Year (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year ("Prior Year Expenses") submitted during the prior Plan Year's run out period and it will reduce the Carryover Maximum by the same amount.

    - For example, assume that you have $800 at the end of the 2014 Plan year and you have elected $2500 for the 2015 Plan Year. On February 1, 2015, you incur a $2700 eligible medical expense. The entire $2,700 expense will be reimbursed with the $2,500 elected for 2015 and $200 of the $800 unused at the end of the 2014 Plan Year. However, only $600 will be available for 2014 Plan Year expenses submitted during the run out period for the 2014 Plan year and your 2014 Carryover Maximum is reduced to $300 ($500 maximum minus the $200 already used). Further assume that after reimbursement of the $2,700 expense that was incurred on February 1, 2015 but before the end of the run out period for the 2014 Plan Year, you submit a $750 expense incurred in 2014. Only $600 of that 2014 expense will be reimbursed and you will have no 2014 Carryover for use in the 2015 Plan Year.

- The Carryover does not count against the maximum salary reduction election identified in the Summary Plan Description.

- If you are otherwise eligible for the URM FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

- Under IRS rules, if you have unused URM FSA amounts on the last day of a Plan Year in a general purpose URM FSA (i.e., anything other than a $0 balance), you (and your spouse, if you are married) cannot contribute to an HSA during the following plan year. Unless your employer allows you to waive any Carryover eligibility and/or direct such amounts to a limited purpose URM FSA (if offered) you must exhaust your general purpose URM FSA account prior to the last day of the Plan Year to retain HSA eligibility.

- You must be a participant in the URM FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

Q-12. Will I be taxed on the DDC benefits I receive?

You will not normally be taxed on your DDC benefits, up to the limits set out in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-13. What is the household and Dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment-Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment-Related Expenses (to a maximum credit amount of $1050 for one Qualifying Individual or $2100 for two or more Qualifying Individuals) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment-Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have

been $3,600 X 32% = $1152, because the entire $3,600 expense would have been taken into account, not just the first $3,000.

Q-14. If I participate in the DDC, will I still be able to claim the household and Dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified Dependent care expenses may be eligible for the Dependent care credit.

Q-15. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in a lower income tax bracket, you may come out ahead by including the DDC benefits in income, and claiming the credits for Dependent care. On the other hand, it will generally be better to treat DDC benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-16. What happens to unclaimed Reimbursements?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical and/or Employment-Related Expense was incurred shall be forfeited.

Q-17. What happens if a Claim for Benefits under the URM or DDC is denied?

You will be notified if your claim under the Plan is denied. The notice will be furnished to you as soon as reasonably possible but no later than 30 days after the Plan Administrator (or its designated claims administrator identified in the reimbursement form) receives your claim. However, if for reasons beyond the control of the claims reviewer, more time for processing your claim is needed, the applicable claims reviewer may take an extension of not more than 15 days following the end of the 30-day period. You will be notified of this extension before the initial 30 days has expired, and the notice will explain why an extension is necessary and the date a decision is expected to be rendered. If the reason for the extension is because you failed to submit complete information necessary to decide the claim, you will have 45 days from the notice of the extension in which to provide the information. The time period for making a decision will be suspended until the earlier of the date that you submit the necessary information or the end of the 45-day period.

The notice of the denial will include the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary;
- instructions on how to appeal the denied claim (including the applicable time periods) and the identity of the individual(s) who will review the denied claim; and
- Any other information required by applicable law.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. The notice will contain the same type of information described above and it will indicate whether there are one or two levels of appeals. If there are two levels of appeals, the decisions on review will be made no later than 30 days after the request for each review is received. The reviews upon appeal (whether one level or two) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in a previous review. In no event will a determination upon review be made by the same individual(s) who made previous determinations or someone who is a subordinate of any individual who made such previous determinations. The Plan Administrator is the claims fiduciary responsible for making final claim decisions under the Plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-18. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the URM only, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

When Coverage May Be Continued

If you are a Participant in the URM, then you have a right to choose continuation coverage under the URM if you lose your coverage because of a reduction in your hours of employment; or a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage due to the death of your Spouse; a voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment; or the divorce or legal separation from your Spouse.

In the case of a Dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost because of: the death of the employee; a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment; his or her parents' divorce or legal separation; or his or her loss of Dependent status. A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries."

NOTE: Notwithstanding the preceding paragraphs, you generally will not have the right to elect COBRA continuation if the amount you have contributed for URM at the time of the COBRA Qualifying Event is less than the amount of URM reimbursements you have received. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If you do not choose continuation coverage, your coverage under the URM will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator identified in the Plan Information Summary in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later date of the event or the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date the qualifying event occurred, and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered dependents who reside with the Spouse. You may be required to provide additional documentation (e.g., a copy of the divorce decree).

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Summary. Failure to return the Election Form(s) within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- After you elect COBRA continuation coverage, the date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;
- After you elect COBRA continuation coverage, the date that you first become entitled to Medicare; or
- The date the employer no longer provides group health coverage to any of its employees.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the URM and DDC indefinitely, it has the right to modify or terminate the programs at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-20. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) group health plans such as the URM and the third party service providers are required to take steps to ensure that certain “protected health information" is kept confidential. Attached as Appendix II to this SPD (included in the HIPAA packet) is a summary of your rights and obligation under HIPAA. You may receive a separate notice that outlines the Employer's health privacy policies in more detail.

Q-21. Is there any other important information that I should know about the Reimbursement Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name has also been provided in the Plan Information Summary.

ERISA Rights

The URM may be an ERISA welfare benefit plan (unless the employer is a governmental employer or the plan is a “church plan” as defined in the applicable regulations). As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-19 of this appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the URM is subject to HIPAA's portability rules:) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

APPENDIX II TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Summary of URM HIPAA Privacy Policies and Procedures

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the URM claims reimbursed under the Plan for Plan administration purposes. This summary applies to all of the medical records we maintain with regard to the URM. Your personal doctor or health care provider will have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with health coverage under the URM, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. In accordance with Section 10.18 of the Plan, the following is a summary of procedures adopted by the Employer to ensure that both Employer and any third party service providers treat your PHI with the level of protection required by HIPAA. You may receive a separate notice that provides more detailed information regarding the procedures adopted by Employer.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. **In the event this summary conflicts with the separate Privacy Notice from Employer, the separate Privacy Notice controls.**

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. Except as otherwise provided in the separate Privacy Notice that may be provided to you, these employees consist of the members of the Personnel Benefits Department of Employer who assist in administration of URM claims**.** These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of the SPD, Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of URM administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan administrative operations. These uses and disclosures are necessary to run the Plan.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Personnel/Benefits Office, except as otherwise set forth in any separate Privacy Notice provided to you by Employer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Personnel/Benefits Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Personnel Office except as otherwise provided in the separate Privacy Notice. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Personnel Office except as otherwise provided in the separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.