SUMMARY PLAN DESCRIPTION

for the

IOWA CITY COMMUNITY SCHOOL DISTRICT
FLEXIBLE SPENDING PLAN

V.1 2015

Introduction

This document and the attached Adoption Agreement are intended to be the Summary Plan Description (SPD) of the Section 125 Cafeteria Plan (the "Plan") sponsored by the Employer indicated in Section 1.a. of the Adoption Agreement.

A cafeteria plan is an employee benefit program that allows employees to choose from among a variety of different types of Employer-provided group benefit coverage (Qualified Benefits) based on their individual needs. This Plan is designed to comply with Section 125 of the Internal Revenue Code to act as a funding mechanism to permit eligible employees to pay the premium costs of any applicable Qualified Benefits on a pre-tax basis. Under the Plan, the Qualified Benefits elected may be paid for with Employer-provided Benefit Credits, pre-tax employee salary reduction contributions, after-tax employee salary reduction contributions, or a combination of these methods. The Qualified Benefits available under your cafeteria plan and the applicable funding methods are outlined in Sections 6 and 8 of the Adoption Agreement.

The SPD describes the basic features of the Plan and your rights as a participant. It does not replace the formal, legal Plan document. In the event of a conflict between the terms of this SPD and the Plan document, the Plan document will govern.

This SPD is intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Although the Dependent Care FSA and Health Savings Accounts are not subject to ERISA, we have included a description of these in this document for your convenience. Your rights under the Plan are legally enforceable. If you need assistance in understanding any part of this summary, contact the Plan Administrator at the contact information provided in Section 4 of the Adoption Agreement. However, please remember that oral statements relating to the Plan are not considered legally binding.

Finally, although your Employer intends to continue the Plan indefinitely, it reserves the right to terminate or amend it in any way, at any time, without notice. If the Plan is amended or terminated, your rights and benefits under the Plan may also be amended or terminated.

How does the Cafeteria Plan work?

Before the beginning of your initial eligibility date or the start of a new Plan Year, eligible employees will be given the opportunity to participate in the Cafeteria Plan. Participants in the Cafeteria Plan can have the cost of their coverage under the Qualified Benefits selected in Section 6 of the Adoption Agreement subtracted from each paycheck on a pre-tax or after-tax basis as selected in Section 6 of the Adoption Agreement. If selected in Section 8 of the Adoption Agreement, Employer-provided Benefit Credits may also be used to pay for the selected Qualified Benefits.

The amount of paycheck reduction for coverage in any Qualified Benefits selected in Section 6.a. of the Adoption Agreement will be automatically adjusted as the cost of coverage under such plans increases or decreases. No similar adjustments will be made during the Plan Year in the amount of the paycheck reduction under Qualified Benefits listed in Section 6.b. of the Adoption Agreement.

What are the procedures for becoming a Plan participant?

You are eligible for participation in the Plan upon completion of the eligibility requirements outlined in Section 5 of the Adoption Agreement. If you wish to participate in the Plan, you must complete a Participation Election Form and submit it to the Plan Administrator within 30 days following the date you become eligible to participate. If so elected in Section 6.c. of the Adoption Agreement, certain Qualified Benefits will be automatically paid from pre-tax salary reduction contributions unless you elect to have them paid with after-tax contributions.

Once you are enrolled in the Cafeteria Plan, your benefit elections under Section 6.a. of the Adoption Agreement will remain in effect for each subsequent Plan Year unless you make a different election during the Plan's Open Enrollment Period. Notwithstanding the preceding, if so elected in Section 6.e.(2) of the Adoption Agreement, you must make new elections with respect to all Qualified Benefits for each new Plan Year. Elections under Section 6.b. of the Adoption Agreement must be made each Plan Year.

Open Enrollment Period is the period of time before each new Plan Year, as determined by the Plan Administrator, during which changes to the Cafeteria Plan elections may be made.

What are the advantages of contributing with "pre-tax" dollars?

In a Cafeteria Plan, employee pre-tax Salary Reduction Contributions for coverage in selected Qualified Benefits are subtracted from your paycheck before federal income taxes or FICA taxes are calculated. Because the Cafeteria Plan results in less "taxable" income, you pay fewer taxes and have more after-tax money to spend.

Suppose your monthly gross pay is $2,500.00 and your cost for health coverage is $140.00 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65% of gross pay. If your health coverage is paid on a pre-tax basis under the Cafeteria Plan, you will be considered to have received $2,360.00 gross pay rather than $2,500.00, with $140.00 contributed for health coverage. This lowers your taxable income, and means your take-home pay will be $1,825.00 with the pre-tax Cafeteria Plan. If you pay for your coverage on an after-tax

basis, your take-home pay is $1,794.00. Thus you save $31.00 per month ($372.00 per year) by participating in the Cafeteria Plan. The table below illustrates this savings.

	Without Cafeteria Plan	With Cafeteria Plan
Gross Pay	$2,500	$2,500
Pre-Tax Medical Plan Contribution	0	140
Taxable Income	$2,500	$2,360
Federal Income Tax (15%)	375	354
FICA Tax	191	181
Post-Tax Medical Plan Contribution	140	0
Net Income	$1,794	$1,825

What are Qualified Benefits?

Qualified Benefits are the various group insurance and fringe benefit plans selected by the Employer and offered under the Cafeteria Plan. Qualified Benefits can be divided into two different types; the premium payment type of benefit (as selected in Section 6.a. of the Adoption Agreement) and the flexible spending account (FSA) type of benefit (as selected in Section 6.b. of the Adoption Agreement). Premium Payment Benefits selected in Section 6.a. are underwritten or administered by an insurance company or third party administrator, and are governed by the booklets, certificates of coverage and other plan documents provided to you by the insurance company or third party administrator. Flexible Spending Account (FSA) and Dependent Care benefits, if selected in Section 6.b. of the Adoption Agreement, are governed by the Section 125 Cafeteria Plan Basic Plan Document and the attached Adoption Agreement.

What are Benefit Credits?

Benefit Credits, if elected in Section 8 of the Adoption Agreement, are credits that your Employer may provide to help you pay for part or all of the Qualified Benefits under the Plan. Section 8 of the Adoption Agreement outlines who is eligible to receive Benefit Credits, the amount of such Benefit Credits and the Qualified Benefits that such Benefit Credits can be applied to. Additional information regarding Benefit Credits will also be provided on the Participation Election Form. The Employer may change the amount of Benefit Credits at its discretion each Plan Year.

If I decide to participate, can I change my mind later?

Generally, you cannot change or revoke your election during the Plan Year although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections only during the Open Enrollment Period. There are several 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 within 30 days of any of the following events:

1. *Change in Status*. Change in Status includes the events described below, as well as any other events which the Plan Administrator determines are permitted under IRS regulations:

- A change in your marital status (such as marriage, legal separation, annulment, divorce or the death of your Spouse);

- A change in the number of your dependents (such as by birth, death, adoption or placement for adoption);

- Any of the following events that changes the employment status of you, your Spouse, or your dependents and causes a change in benefit plan coverage for the person affected by the change (if the individual becomes or ceases to be eligible for a particular benefit because of such change): termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; a change in the employee's, spouse's or dependent's employment status (such as switching from salaried to hourly paid, union to non-union, or full-time to part-time);

- Unless otherwise elected in Section 6.e. of the Adoption Agreement, you may also prospectively revoke or modify your group health plan election (and hence, your premium elections under this Plan) once during the Plan Year (for yourself and any related individuals) if you:

  (a) enroll or intend to enroll in another plan that provides minimum essential coverage because you reasonably expected to average at least 30 hours of service per week and experience a reduction in the number of hours worked so that your average expected hours are less than 30 per week (even if that reduction would not cause you to cease eligibility under the group health plan); or
  (b) revoke an election of group health plan coverage for yourself and any related individuals because you are eligible to and enroll/intend to enroll in a Qualified Health Plan offered through an Exchange during a special enrollment period or annual enrollment period offered through the Exchange

- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (e.g., age);

- A change in your, your spouse's or your dependent's place of residence which causes a change in benefit plan coverage for the person affected by the move (if the individual becomes or ceases to be eligible for a particular benefit because of such change, such as moving in or out of an HMO service area); and

If you wish to change your election based on a Change in Status, you must establish that the change is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event only if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to change your election based on Change in Status:

- *Loss of Dependent Eligibility*. For health-related benefits, a special rule governs which type 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 such health-related benefits for any individual other than one affected by the event, would fail to correspond with that Change in Status. Hence, you may only cancel health-related benefits for the affected spouse or dependent.

- *Gaining 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 plan 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.

A "change in status" for the Dependent Care FSA includes marriage or divorce; death of the spouse or child; birth or adoption of a child; your spouse's commencement or termination of employment; an unpaid leave of absence or change from full-time to part-time employment (or vice versa) of you or your spouse; a significant change in the cost of your dependent care services (other than for services provided by a relative); and certain other events.

2. *Special Enrollment Rights*. (Applicable primarily to medical insurance benefits, listed in Section 6.a. of the Adoption Agreement; this usually does not apply to dental and vision plans.) If you, your spouse and/or a dependent are entitled to special enrollment rights under a group medical 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 you or they had other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., 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 (and if applicable, dental and/or vision coverage) under the Plan for yourself and your eligible dependents who lost such coverage.

In addition, you may make a change to your medical insurance (and if applicable, dental and vision) due to marriage, birth, adoption or placement for adoption of a child with you. Written requests received within 30 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your spouse, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 30 days of your marriage will permit you, your spouse and your children, if elected, to be added to your coverage prospectively on the first day of the month following the date of your written request.

3. *Certain Judgments 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 (known as a "Qualified Medical Child Support Order"), you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

4. *Entitlement to Medicare*. If you, your spouse, or a dependent becomes entitled to Medicare, you may cancel that person's medical coverage. Similarly, if you, your spouse, or a

dependent who has been entitled to Medicare loses eligibility for such, you may, subject to the terms of the underlying benefit plan, elect to begin or increase that person's medical coverage.

5. *Medicaid or CHIP*. If your, your spouse's or a dependent's Medicaid or CHIP coverage ends because of loss of eligibility or you, your spouse or dependent become eligible for premium assistance under Medicaid or CHIP, you may change your election to provide or revoke coverage under the Plan.

6. *Change in Cost*. If the Plan Administrator notifies you that the cost of your coverage under the Plan *significantly* increases during the Plan Year, you may choose either to make an increase in your contributions or revoke your election and receive coverage under another Plan option which provides similar coverage. For *insignificant* increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. (This "Change in Cost" exception is not applicable to any Qualified Benefits selected under Section 6.b. of the Adoption Agreement.)

Example: Mike is covered under the PPO option for medical coverage. If the cost of this option significantly increases during a period of coverage, Mike may make a corresponding increase in his payments or may instead revoke his election and elect coverage under another option for medical coverage under the Plan, such as the HMO option.

7. *Change in Coverage*. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Plan option which provides similar coverage. Also, if during the Plan Year the Plan adds or eliminates a coverage option, you may elect the newly-added option or elect another Plan option (when a Plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another Plan option which provides similar coverage. Further, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's, or dependent's employer, so long as: (i) his or her employer's plan permits its participants to make an election change permitted under IRS regulations; or (ii) this Plan permits you to make an election for a period of coverage that is different from the period of coverage under his or her employer's plan. (This "Change in Coverage" exception is not applicable to any Qualified Benefits selected under Section 6.b. of the Adoption Agreement.)

8. *Family and Medical Leave*. Changes to your health coverage election can also be made on account of commencement of or return from leave under the Family and Medical Leave Act ("FMLA").

9. *Change in HSA Elections*. If HSA benefits are selected under Section 6.b. of the Adoption Agreement and you have elected to make HSA contributions on a pre-tax basis under the Plan, then notwithstanding anything to the contrary in this summary, you may increase, decrease or revoke your HSA benefits election on a prospective basis at any time during the Plan Year in accordance with the Plan's administrative procedures.

Can I pay for domestic partner benefits through the Plan?

The booklets and/or certificates of coverage provided to you by the insurance company or third party administrator that is underwriting or administering the Qualified Benefits of Section 6.a. of

the Adoption Agreement will tell you whether or not the Plan provides coverage for domestic partners. If domestic partner coverage is offered, you may be able to cover your domestic partner and the dependents of your domestic partner. The domestic partner's share of the premiums for these benefits, however, cannot be paid on a pre-tax basis under this Plan unless the domestic partner (and likewise, the dependents of the domestic partner) qualifies as a "dependent" for income tax purposes under Internal Revenue Code Section 152. Also, you can make a claim for expenses of a domestic partner (and his or her dependents) under the Health FSA only if they have dependent status under the Internal Revenue Code. The IRS requires your Employer to report the fair market value of your domestic partner's (and his or her dependents) cost for coverage as taxable income to you (either by requiring their premium cost to be paid on an after-tax or imputed income basis) unless the domestic partner (and dependents) qualifies as your dependent for federal income tax purposes. You should consult with your tax advisor as to whether or not your domestic partner qualifies as a dependent for federal income tax purposes. Caution: state laws may require different state income tax treatment.

Can I pay for my Same-Sex Spouse's benefits through the Plan on a Pre-Tax Basis?

Yes. Beginning on and after July 26, 2013, the definition of "Spouse" under the Plan shall mean an individual, including an individual of the same sex, who is legally married to you, provided the marriage was validly entered into and designated as "marriage" in a state whose laws authorize such marriage, even if you are living in a state that does not recognize the validity of same-sex marriage. The term "Spouse" will not include individuals (whether of the same sex or opposite sex) who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized by state law that is not designated as "marriage" under the laws of the state, Caution: state laws may require different state income tax treatment.

Can I pay for benefits for my adult child through the Plan?

The booklets and/or certificates of coverage provided to you by the insurance company or third party administrator that is underwriting or administering the Qualified Benefits of Section 6.a. of the Adoption Agreement will tell you whether or not such benefits provide coverage for children and, if so, up to what age. For example, under federal law, employer-sponsored group health plans (which in many cases does not include dental or vision) that provide dependent coverage must make that coverage available to adult children up to age 26. The Plan will permit your child's premium cost for any Employer-sponsored health plan coverage to be paid by you on a pre-tax basis if the child has not attained age 27 by the end of the tax year. Beyond the end of the tax year in which your child attains age 27, the cost of any Employer-sponsored health plan coverage for your child may only be paid on a pre-tax basis if your child qualifies as your tax dependent for federal income tax purposes under Internal Revenue Code Section 152.

How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, your Employer will continue to maintain your medical insurance benefits, HSA Benefits, and Health FSA Benefits, if applicable, under the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all medical insurance benefits and Health FSA coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to

continue coverage as well). If so, you will pay your share of Plan contributions by the method normally used during any paid leave (for example, on a pre-tax basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), you may opt to continue your medical insurance benefits and Health FSA benefits during the period of FMLA leave or cancel them. If you continue these benefits during the period of FMLA leave, you may pay your share of the contributions in one of three ways, as designated by your Employer:

1. with after-tax dollars while on leave;
2. with pre-tax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation; or
3. by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your medical insurance benefits or Health FSA benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by FMLA. With regard to Health FSA benefits, if your coverage ceased, you will be permitted to elect whether to be reinstated in the Health FSA benefit at the same coverage level as was in effect before FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA benefits will equal the amount withheld before FMLA leave, and you cannot submit reimbursement requests for claims incurred during the period of leave.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by your Employer.

What are some disadvantages of Plan participation?

Social Security and Medicare benefits are based on FICA taxes paid. For 2015, the FICA tax rate is equal to 7.65% of the first $118,500 in compensation and 1.45% on remaining compensation of up to $200,000 and 2.35% above $200,000. If you participate in the Cafeteria Plan, you will pay less FICA taxes. In other words, your FICA taxes will be reduced if you elect under the Cafeteria Plan to make pre-tax contributions to the Qualified Benefits offered under the Plan. As a result, your survivorship, disability and retirement benefits under Social Security and Medicare may be reduced. You should consult with your tax advisor about the effect on your Social Security and Medicare benefits.

Participation in the Cafeteria Plan may also affect your tax deductions and tax credits. For example, if you participate in the Cafeteria Plan, your contributions for coverage under any medical plan, dental plan and/or Health FSA Plan are made on a "pre-tax" basis, therefore you

will not be able to treat these contributions as an itemized deduction on Schedule A of your Form 1040. Consult your tax advisor if you have any questions.

What are the Plan's procedures for Qualified Medical Child Support Orders?

Ask the Plan Administrator for a copy of the Plan's policy regarding treatment of Qualified Medical Child Support Orders (or QMCSOs).

Health Flexible Spending Account (FSA) Plan

What is the Health FSA Plan?

The Health FSA Plan, if selected in Section 6.b. of the Adoption Agreement, enables you to make pre-tax contributions through the Cafeteria Plan and then to receive reimbursements or payments from the Health FSA for any Qualifying Medical Care Expenses incurred by you or your tax dependents.

Who can participate in the Health FSA Plan?

Employees who have met the eligibility requirements under Section 9 of the Adoption Agreement are eligible to participate in the Health FSA Plan.

What is my Health FSA Account?

If you elect Health FSA benefits, an account called a Health FSA Account will be set up in your name to keep a record of the pre-tax contributions you have elected for the Plan Year as well as any Benefit Credits you may be entitled to. The Health FSA Account is merely a recordkeeping account and is not funded and does not bear interest. All reimbursements are paid from the general assets of the Employer.

NOTE: If you elect Health FSA benefits you cannot also elect HSA benefits or otherwise make contributions to an HSA unless you elect coverage under a Limited Purpose Health FSA or a Post-Deductible Health FSA, assuming those are provided under the Plan (see Section 9.g. of the Adoption Agreement). If you are married, your spouse will also be ineligible to make HSA Contributions. Please refer to the section on Health Savings Accounts (HSA) for more information.

What is a Limited-Purpose Health FSA?

A Limited-Purpose Health FSA is a Health FSA that only pays or reimburses permitted coverage benefits (such as vision care, dental care or preventive care) that are not otherwise covered under a High Deductible Health Plan (HDHP).

What is a Post-Deductible Health FSA?

A Post-Deductible Health FSA is a Health FSA that only pays or reimburses medical expenses for preventive care or medical expenses incurred after the minimum annual High Deductible Health Plan (HDHP) deductible is satisfied.

Who pays for the cost of coverage under the Health FSA Plan?

Generally, you pay for the entire cost of your coverage under the Health FSA Plan. However, if elected in Section 8 of the Adoption Agreement, Benefit Credits provided by the Employer may be used to fund your Health FSA Account.

What are the advantages of participating in the Health FSA Plan?

As a participant in the Health FSA Plan, you make pre-tax contributions through the Cafeteria Plan. These contributions are not subject to federal income taxes or state income taxes (except NJ and PA) and are exempt from federal employment taxes (known as “FICA”). Also, you are not

taxed on the reimbursements you receive under the Health FSA Plan. In effect, you are able to use pre-tax dollars to pay for your and your dependents' Qualifying Medical Care Expenses, without being taxed on either the contributions to or the reimbursements from the Health Care FSA. You can claim for expenses of your child up to age 27.

What are the maximum and minimum Health FSA Benefits that I may elect?

The IRS has capped the maximum amount that a Health FSA may reimburse a Participant for a Plan Year for Qualifying Medical Expenses. This amount may be adjusted in future years for future changes in the cost of living. You may choose any amount of Health FSA benefits that you desire, subject to the minimum and maximum amounts listed in Section 9.e. of the Adoption Agreement. Carryover amounts, if any, allowed under the Plan will not count toward the maximum amount of Health FSA benefits that you may elect for a Plan Year. You will be required to pay the annual Health FSA contribution equal to the coverage level you have chosen, unless the Employer has elected to provide you with Benefit Credits under Section 8 of the Adoption Agreement.

What amounts are available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected (reduced by any prior reimbursements made with respect to the same Plan Year) will be available to reimburse you for your Qualifying Medical Expenses incurred during the Plan Year, regardless of the amount you have contributed when you submit the claim. For example, suppose you elected $1,200 of coverage and contribute a total of $200 to your Health FSA Account during January and February. You haven't made any prior claims for reimbursement for the Plan Year, but on March 1st you incur a medical expense of $400. You submit that claim for reimbursement on March 5th. As long as the claim meets all applicable requirements, $400 is available for reimbursement even though you have only contributed $200.

What are Qualifying Medical Care Expenses?

Qualifying Medical Care Expenses are expenses incurred by you, your spouse or your tax dependents for medical care (including hospital bills, doctor bills, prescription drugs, over-the-counter drugs, annual deductibles and co-pays), dental care, and vision care which are not covered under other insurance coverage but which qualify for tax deduction under Section 213 of the Internal Revenue Code.

Qualifying Medical Care Expenses DO NOT INCLUDE (a) the payment of any premium for medical coverage under any plan maintained by any employer or other entity; (b) expenses for voluntary cosmetic surgery; and (c) any other expense which does not qualify for tax deduction under Code Section 213.

In addition, expenses for over-the-counter medicines or drugs will not be reimbursed unless such medicine or drug is prescribed by a physician or is insulin.

When are claims incurred?

In general, Qualifying Medical Care Expenses are incurred at the time services are rendered and not when payment is made. However, there are special rules for orthodontia services. The Health FSA Plan will reimburse you for orthodontia services before the services are provided, but only to

the extent you actually made the payment in advance of the orthodontia services and the orthodontist actually requires advance payment for the services.

All other Qualifying Medical Care Expenses which require pre-payment other than orthodontia services (including prenatal payments and infertility treatments) must be allocated to the services as they are provided. You must ask your health care provider to allocate specific dollar amounts for services as they are provided for all prepayments except orthodontia.

Can I make changes to my Health FSA Plan election?

Your contributions to the Health FSA Plan are made through the Cafeteria Plan on a pre-tax basis. Making changes to your Health FSA coverage is subject to IRS rules for Cafeteria Plans. Refer to page 3 in this summary for information about making changes to your Plan coverage.

What is the "use-it-or-lose-it" rule?

Your Health FSA Account is subject to the Internal Revenue Service's "use-it-or-lose-it" rule. Under this rule, only those Qualifying Medical Care Expenses that were incurred during the Plan Year can result in reimbursements or payments from your Health FSA Account. Notwithstanding the preceding, if elected in Section 12 of the Adoption Agreement, you can also be reimbursed from unused amounts remaining in your Health FSA Account at the end of the Plan Year for Qualifying Medical Care Expenses incurred during the Grace Period. The Plan Year, plus the Grace Period, if any, are referred to as the Period of Coverage.

Alternatively, the IRS has modified the "use-it-or-lose-rule" for Health FSA Accounts to allow Participants to carry over up to $500 of unused amounts from the preceding Plan Year into the following Plan Year. A Health FSA Plan is permitted to allow a Grace Period or a Carryover option, but not both during the same Plan Year. Carryover amounts may not be converted to other taxable or non-taxable benefits, or cashed out, and will not count toward the maximum Health FSA Account amount you elect for a Plan Year.

Can the Health FSA Plan limit my reimbursements and payments?

The Plan Administrator may be required to limit the benefits that highly compensated employees and key employees receive under the Health FSA Plan.

How do I obtain reimbursements from the Health FSA Plan?

To obtain reimbursement or payment of Qualifying Medical Care Expenses, you must submit your invoices, receipts, and other statements directly to the Plan Administrator (or, if elected in Section 14.a. of the Adoption Agreement, the Contract Administrator) which show that the expense has been incurred. The documentation can be submitted before the expense has been paid, but not before the expense has been incurred. The Plan Administrator (or Contract Administrator) will reimburse you for the expense.

If the Employer has selected the automatic reimbursement option in Section 9.f. of the Adoption Agreement, you may elect to have certain claims automatically submitted for reimbursement.

Notwithstanding the preceding, if the Plan provides for Qualified Reservist Distributions in Section 9.h. of the Adoption Agreement and you are ordered or called to active duty for a period in excess of 179 days or for an indefinite period, you may receive a distribution of all or a portion of the

balance in your Health FSA Plan, provided such distribution is made during the period beginning on the date of such order or call and ending on the last day that reimbursement could otherwise be made under the Health FSA Plan for the Plan Year that included the date of such order or call.

If I terminate employment, can I continue my Health FSA Plan coverage?

Generally, most health FSA plans meet certain conditions with respect to maximum benefits and benefit availability and are "excepted" from COBRA requirements. If your Health FSA Plan is an "excepted" plan, you, or your qualified beneficiaries, may have limited COBRA continuation coverage rights with respect to the Health FSA Plan. Your eligibility for this limited COBRA continuation coverage will be determined based on how much of your annual reimbursement amount has been distributed to you as of the date of the COBRA qualifying event. COBRA coverage will not be offered to you if you have "overspent" your excepted Health FSA Benefits as of the date of your COBRA qualifying event. Also, for excepted health FSAs, the limited health FSA COBRA continuation coverage period available to qualified beneficiaries who have not overspent their Health FSA Benefits ends as of the end of the Plan Year in which the COBRA qualifying event occurs.

A health FSA is an excepted health FSA if health plan eligibility, the benefits paid to participants and the cost of these benefits to the participants meet three requirements. First, the maximum benefit payable to each participant (the total amount of reimbursement available for the plan year) cannot exceed the greater of (a) the participant's salary reduction amount for the year times two, or (b) the salary reduction amount for the year plus $500. Second, the Employer must offer other major medical plan coverage and this other coverage must be consistently available to all employees who are eligible to participate in the Health FSA Plan. Third, the maximum COBRA premium amount for a Plan Year must equal or exceed the maximum benefit available under the Health FSA Plan for that Plan Year.

Health FSA plans that do not meet the conditions listed in the preceding paragraph are "non-excepted" plans. If you are a participant in a "non-excepted" health FSA plan, you, or your qualified beneficiary, will be eligible for COBRA continuation coverage for the entire applicable COBRA period. If you have any questions concerning your COBRA continuation coverage with respect to the Health FSA Plan in which you are participating, you should contact the Plan Administrator.

It may be to your advantage to continue coverage under the Health FSA Plan after termination of employment, so that you can obtain reimbursements or payments with respect to the entire amount you have contributed under the Health FSA Plan.

How does the HIPAA Privacy Rule apply to the Health FSA Plan?

This section describes the medical information privacy practices of the Health FSA Plan and that of any third party that assists in the administration of the Health FSA Plan's claims. For a more complete explanation, see the Health FSA Plan's Notice of Privacy Practices.

The Health FSA Plan is committed to protecting medical information about you. The Health FSA Plan may disclose protected health information (PHI) to the Employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the Employer that the Health FSA Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them. The Health FSA Plan may disclose summary

health information to the Employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Health FSA Plan.

The Health FSA Plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Health FSA Plan may not disclose PHI to the Employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer. A limited number of employees of the Employer will have access to PHI for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are listed in Section 4.e. of the Adoption Agreement.

The following categories describe different ways that the Health FSA Plan uses and discloses PHI. Not every use or disclosure in a category will be listed. However, all of the ways the Health FSA Plan is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Health FSA Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Health FSA Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital.

For Payment. The Health FSA Plan may use and disclose PHI about you to determine eligibility for Health FSA Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Health FSA Plan, or to coordinate plan coverage.

For Health Care Operations. The Health FSA Plan may use and disclose PHI about you for other Health FSA Plan operations which are necessary to run the Health FSA Plan. For example, the Health FSA Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities.

As Required By Law. The Health FSA Plan will disclose PHI about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. The Health FSA Plan may use and disclose PHI 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.

To Facilitate Claims Under Employer Plans. Your health information may be disclosed to another health plan maintained by the Employer for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Employer to administer benefits under the Health FSA Plan, such as to determine a claims appeal.

Provide You With Information. The Health FSA Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Health FSA Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Health FSA Plan may release PHI about you as required by military command authorities. The Health FSA Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Health FSA Plan may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. The Health FSA Plan may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Health FSA Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Health FSA Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Health FSA Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Health FSA Plan may disclose PHI about you in response to a court or administrative order. The Health FSA Plan may also disclose PHI 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. The Health FSA Plan may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Health FSA Plan is unable to obtain the person's agreement; about a death the Health FSA Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Health FSA Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Health FSA Plan may also release PHI about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Health FSA Plan may release PHI 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, the Health FSA Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

You have the following rights regarding PHI the Health FSA Plan maintains 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 Health FSA Plan benefits. If you request a copy of the information, the Health FSA Plan may charge a fee for the cost of copying, mailing, or other supplies associated with your request. The Health FSA Plan may deny your request to inspect and copy in certain limited circumstances. 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 the Health FSA Plan has about you is incorrect or incomplete, you may ask the Health FSA Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health FSA Plan. The Health FSA Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Health FSA Plan may charge you for the costs of providing the list. The Health FSA Plan 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.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Health FSA Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Health FSA Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. The Health FSA Plan is not required to agree to your request however.

Right to Request Confidential Communications. You have the right to request that the Health FSA Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Health FSA Plan only contact you at work or by mail. The Health FSA Plan will not ask you the reason for your request. The Health FSA Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Health FSA Plan will be made only with your written authorization. If you provide the Health FSA Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Health

FSA Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Health FSA Plan is unable to take back any disclosures the Health FSA Plan has already made with your permission, and that the Health FSA Plan is required to retain its records of the benefits that the Health FSA Plan provided to you.

How does the HIPAA Security Rule apply to the Health FSA Plan?

The Employer will put into place and follow administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI (electronic protected health information) that the Employer creates, receives, maintains or transmits on behalf of the Health FSA Plan, except as stated below.

The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to access or use such ePHI for the proper administration of the Health FSA Plan (as set forth in Section 4.e. of the Adoption Agreement), or for such other reasons as may be proper under HIPAA Security Rule. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them. The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the Health FSA Plan agrees to implement reasonable and appropriate security measures to protect the ePHI. The Employer will report to the Health FSA Plan any security incident of which it becomes aware.

The terms of this section shall not apply if ePHI is disclosed to the Employer pursuant to an authorization which meets the requirements of the HIPAA Privacy Rule, or if the ePHI is summary health information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the Health FSA Plan; or (b) to amend or terminate the Health FSA Plan. In addition, the terms of this section shall not apply if the ePHI disclosed to the Employer is information concerning whether an individual is participating in the Health FSA Plan.

Dependent Care FSA Plan

What is the Dependent Care FSA Plan?

The Dependent Care FSA Plan, if selected in Section 6.b. of the Adoption Agreement, enables you to make pre-tax contributions through the Cafeteria Plan and then to receive reimbursements or payments from the Dependent Care FSA Plan for any Employment-Related Dependent Care Expenses incurred by you and not reimbursed elsewhere.

Who can participate in the Dependent Care FSA Plan?

Employees who have met the eligibility requirements under Section 10 of the Adoption Agreement are eligible to participate in the Dependent Care FSA Plan.

What is my Dependent Care FSA Account?

If you elect Dependent Care FSA benefits, an account called a Dependent Care FSA Account will be set up in your name to keep a record of the pre-tax contributions you have elected to make for the Plan Year as well as any Benefit Credits you may be entitled to. The Dependent Care FSA Account is merely a recordkeeping account and is not funded and does not bear interest. All reimbursements are paid from the general assets of the Employer.

Who pays for the cost of coverage under the Dependent Care FSA Plan?

Generally, you pay for the entire cost of your coverage under the Dependent Care FSA Plan. However, if elected in Section 8 of the Adoption Agreement, Benefit Credits provided by the Employer may be used to fund the Dependent Care FSA Plan.

What are the advantages of participating in the Dependent Care FSA Plan?

If you participate in the Dependent Care FSA Plan, you make pre-tax contributions through the Cafeteria Plan. These contributions are not subject to federal income taxes and are exempt from FICA taxes. Also, you are not taxed on the reimbursements and payments that you receive under the Dependent Care FSA Plan. In effect, you are able to use pre-tax dollars to pay for your Employment-Related Dependent Care Expenses, without being taxed on either the contributions to or reimbursements from the Dependent Care FSA Plan.

What are Employment-Related Dependent Care Expenses?

Employment-Related Dependent Care Expenses are child care expenses incurred by you which meet the following requirements:

- They are incurred for the care of a Qualifying Individual or for related household services;
- They are paid or payable to a Dependent Care Service Provider; and
- They are incurred to enable you to be gainfully employed for any period for which there are one or more Qualifying Individuals.

Employment-Related Dependent Care Expenses do not include expenses incurred for services outside your household for the care of a Qualifying Individual, unless the Qualifying Individual is under the age of 13 and you are entitled to a tax deduction for such Qualifying Individual , or

unless the Qualifying Individual regularly spends at least eight hours each day in your household. Also, Employment-Related Dependent Care Expenses do not include services at a camp where the Qualifying Individual stays overnight.

What is a Dependent Care Service Provider?

A Dependent Care Service Provider is a person who provides care for a Qualifying Individual or related household services. It includes a dependent care center if the center complies with state and local laws and cares for more than six individuals. It does not include your son or daughter under the age of 19 or anyone you claim as a tax dependent on your federal income tax return.

Who is a Qualifying Individual for purposes of the Dependent Care FSA Plan?

A Qualifying Individual for purposes of the Dependent Care FSA Plan is (1) a child under the age of 13 and for whom you are entitled to a tax deduction, or (2) a tax dependent or spouse who is physically or mentally incapable of taking care of himself or herself and who has the same principal place of abode as you. Other special rules may also apply in determining whether an individual qualifies as your Qualifying Individual.

What are the maximum and minimum Dependent Care FSA Benefits that I may elect?

You may choose any amount of Dependent Care FSA reimbursement that you desire, subject to the minimum and maximum amounts listed in Section 10.e. of the Adoption Agreement. You will be required to pay the annual Dependent Care FSA contribution equal to the coverage level you have chosen, unless the Employer has elected to provide you with Benefit Credits under Section 8 of the Adoption Agreement. Notwithstanding the preceding, the maximum permissible reimbursement amount permitted under IRS regulations is whichever of the following amounts is the smallest:

- Your taxable income for the year;
- The taxable income that is actually or deemed to be earned by your spouse; or
- $5,000 ($2,500 if you and your spouse file separate tax returns rather than a joint return).

Your spouse is deemed to have earned taxable income if your spouse is either a student or is physically or mentally incapable of caring for himself or herself. The amount of deemed income is $250 per month if you have one Qualifying Individual and $500 per month if you have two or more Qualifying Individuals. These limits may change from time to time in accordance with changes to Code Section 21(d)(2).

For example, suppose you and your spouse both work, and each of you earns $28,000 during the year. If you file a joint tax return with the IRS, the maximum benefit that can be received under the Dependent Care FSA Plan for the year is $5,000. On the other hand, if your spouse does not work, the spouse has no taxable income and the maximum benefit you can receive under the Plan is zero.

As you make contributions to the Dependent Care FSA Plan, they are recorded in a Dependent Care FSA Account that is in your name. For example, if you start participating in the Dependent Care FSA Plan on February 1 and contribute $100 to the Dependent Care FSA Plan on February 15 and another $100 to the Dependent Care FSA Plan on February 28, your Dependent Care FSA Account will show a balance of $200 on February 28. The Dependent Care FSA Account is

reduced by the amount of any reimbursements or payments that are made with respect to your dependents, but the Dependent Care FSA Account may not have less than a zero balance.

What is the "use-it-or-lose-it" rule?

Your Dependent Care FSA Account is subject to the Internal Revenue Service's "use-it-or-lose-it" rule. Under this rule, only those Employment-Related Dependent Care Expenses that were incurred during the Plan Year can result in reimbursements or payments from your Dependent Care FSA Account. Notwithstanding the preceding, if elected in Section 12 of the Adoption Agreement, you can also be reimbursed from unused amounts remaining in your Dependent Care FSA Account at the end of the Plan Year for Employment-Related Dependent Care Expenses incurred during the Grace Period. The Plan Year, plus the Grace Period, if any, are referred to as the Period of Coverage. Employment-Related Dependent Care Expenses are deemed to be incurred at the time the services are rendered.

You have until the end of the Run-out Period indicated in Section 13 of the Adoption Agreement to apply for reimbursement or payment of Employment-Related Dependent Care Expenses that were incurred during the Period of Coverage.

If you incur Employment-Related Dependent Care Expenses during the Grace Period, (if one applies), and have amounts remaining in your Dependent Care FSA Account from the prior Plan Year, the expenses are first paid out of funds from the prior year. If any balance remains in your Dependent Care FSA Account for a Plan Year after all reimbursements hereunder, the balance cannot be carried over to reimburse you for future Employment-Related Dependent Care Expenses, and is not available to you in any other form or manner. You forfeit all rights with respect to any unused balance.

Can the Dependent Care FSA Plan limit my reimbursements and payments?

The Plan Administrator may be required to limit the benefits that highly compensated employees and key employees receive under the Dependent Care FSA Plan.

How do I obtain reimbursements or payments from the Dependent Care FSA Plan?

To obtain reimbursement or payment of Employment-Related Dependent Care Expenses, you must submit your invoices, receipts and other statements which show that the expense has been incurred to the Plan Administrator (or, if elected in Section 14.a. of the Adoption Agreement, the Contract Administrator). The documentation can be submitted before the expense has been paid, but not before the expense has been incurred. The Plan Administrator (or Contract Administrator) will reimburse you for the eligible expenses submitted.

For example, suppose that you start participating in the Dependent Care FSA Plan on February 1. You previously signed up with a Dependent Care Service Provider and have already paid the February bill, which was due on February 1 and is for services to be rendered in February. During February, you make pre-tax contributions to the Dependent Care FSA Plan (on February 15 and February 28) which are recorded in your Dependent Care FSA Account. When you present the February bill to the Plan Administrator (or Contract Administrator) for reimbursement or payment, the Plan Administrator will make a distribution from the Plan which is equal to the billing amount (not to exceed the amount in your Dependent Care FSA Account). You can apply the check toward the March payment to the Dependent Care Service Provider that is due on March 1, or

you can keep the check as reimbursement for your February expenditure. The process then repeats itself until the Plan Year plus the Grace Period, if applicable, ends.

If I elect Dependent Care FSA Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefits for the tax-free amounts received by you under the Dependent Care FSA Plan, although the balance of your Employment-Related Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Internal Revenue Code Section 21 (e.g., if you elect $3,000 of coverage under the Dependent Care FSA, but you had Employment-Related Dependent Care Expenses totaling $5,000, you could count the excess $2,000 when calculating the Dependent Care Tax Credit). You should consult with your tax advisor as to which option works better for you.

If I terminate employment, can I continue my coverage under the Dependent Care FSA Plan?

Unless otherwise selected in Section 10.f. of the Adoption Agreement, you stop participating in the Dependent Care FSA Plan when you terminate employment. However, you can receive reimbursement or payment of Dependent Care Expenses that are incurred through the date your employment terminates, up to the amount remaining in your Dependent Care FSA Account.

General Information

How is the Plan administered?

The Plan is administered by your Employer, who acts as Plan Administrator. The Plan Administrator shall perform its duties in its sole discretion and shall determine appropriate courses of action in light of the reason and purpose for which the Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether an individual is entitled to receive any benefit under the terms of the Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Plan Administrator may contract with a Contract Administrator to administer FSA benefits under the Plan. See Section 4.c. of the Adoption Agreement.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to judicial review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under these Plans constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

What happens if my claim for benefits is denied?

Qualified Benefits selected under Section 6.a. of the Adoption Agreement. The applicable insurance company or other designated party will decide your claim in accordance with its claim procedures. If your claim is denied, you may appeal to the relevant party for a review of the denied claim. For more information about how to file a claim and for details regarding the claims procedures for the Qualified Benefits in Section 6.a. of the Adoption Agreement, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description applicable to the benefit selected.

HSA Claims Not Involving Issues Relating to Salary Reduction. Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Other Claims Under the Cafeteria Plan. If (a) a claim for reimbursement under a Flexible Spending Account Plan (FSA) is wholly or partially denied, or (b) you are denied a benefit under the Cafeteria Plan (such as the ability to pay for a Qualified Benefit on a pre-tax basis) due to an issue related to your coverage under the Plan (for example, a determination of a Change in Status; a significant change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), contact the Plan Administrator with any questions.

Can the Plan be terminated or amended?

Although your Employer has established the Plan with the intention of continuing it indefinitely, the uncertainty under which all businesses operate, as well as possible future changes in the law, make it necessary for the Employer to reserve the right to amend or terminate the Plan at any time, without notice subject to any applicable collective bargaining agreement.