

eflexgroup.com, Inc.

SECTION 125 CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

**AS ADOPTED BY
CITY OF MILWAUKEE**

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PLAN INFORMATION

Plan Sponsor, Plan Administrator and Agent for Legal Process:

City of Milwaukee

Claims Administrator:

eflexgroup.com
2740 Ski Lane
Madison, WI 53713
877-933-3539
www.eflexgroup.com

Plan Year:

1/1 – 12/31

Employer EIN:

39-6005532

Plan Number:

501

Plan Type:

Cafeteria plan under Section 125 of the Internal Revenue Code.
The Health Flexible Spending Account is a medical expense reimbursement plan described in Section 105 of the Code.
The Dependent Care Reimbursement Account is a dependent care assistance plan as described in Section 129 of the Code.

Type of Administration:

This is a self-funded plan, administered by the Plan Administrator. The Plan also has a Claims Administrator that provides professional claims processing services.

Plan Funding:

Employees reduce their compensation in the amount necessary to pay for Benefits they elect under this Plan. The Plan Sponsor uses the reduced amount and any Employer Credits to pay Benefits from its general assets.

QMCSO Procedures:

The Plan's procedures for a Qualified Medical Child Support Order ("QMCSO") are available from the Plan Administrator.

If you have questions about the Plan, you may contact the Plan Administrator.

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INTRODUCTION

This Summary Plan Description ("Summary") explains the main provisions of the Plan. **Please read it carefully.** It is important to understand the Plan requirements and the Benefits it can provide for you and your family. If you have any questions after reading the Summary, please contact the Plan Administrator.

The Plan is a complex legal document. This Summary is intended to serve as an easy-to-read explanation of the Plan. Although every effort has been made to make this Summary as accurate as possible, the Summary is not a substitute for the Plan document. The detailed provisions of the Plan, not this Summary, govern the actual rights and benefits to which you are or may be or become entitled.

PART 1 BENEFITS

1. What is the purpose of this Plan?

The purpose of this Plan is to allow you to choose Benefits offered through the Plan and to pay for these Benefits using pre-tax dollars.

2. What Benefits are offered through this Plan?

This Plan offers the types of Benefits listed in Appendix A below.

ELIGIBILITY, ENROLLMENT AND PARTICIPATION

1. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you meet the requirements for participation described in Appendix A below.

2. When am I eligible to participate in the Plan?

You can participate in the Plan as of the dates specified in Appendix A below.

3. How do I elect to participate in the Plan?

You elect to participate in the Plan by filling out an Enrollment Form in which you specify which Benefits you would like and how much of your Compensation you would like withheld for your Benefits. If you select more than one Benefit, you must indicate how much of the "Reduction Amount" should be used to pay for each Benefit.

4. What is my Reduction Amount?

Your Reduction Amount is the amount of future Compensation you agree to exchange for Benefits on your Enrollment Form.

5. When can I enroll in the Plan?

You can enroll during the following Enrollment Periods:

- Initial Enrollment Period:
The first time you may enroll for benefits is the Initial Enrollment Period designated by the Employer following your initial eligibility for participation in the Plan as outlined in Appendix A below.
- Open Enrollment Period:
The Open Enrollment Period is the period designated by the Employer each year in which you can elect to change and/or continue your elections for the next Plan Year.

6. What happens if I don't return my Enrollment Form?

If you fail to return your Enrollment Form, you will be deemed to have made the elections specified in Appendix A below.

7. How long does my Enrollment apply?

Your Enrollment will be binding for the Plan Year. If you begin participating in the Plan after the beginning of the Plan Year, your Enrollment will be binding for the remainder of the Plan Year. If you terminate participation, your Enrollment will terminate as of the date your participation terminates.

8. When do I have to complete a new Enrollment?

You should complete an Enrollment Form during the Open Enrollment Period prior to each Plan Year. If you fail to return your Enrollment Form, you will be deemed to have made the elections specified in Appendix A below.

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

Generally, you cannot change your elections during the Plan Year. However, some Benefits may permit you to change your elections if specific circumstances occur. The circumstances which would permit you to change your election during the Plan Year are described for each Benefit below.

10. What happens if I am rehired after terminating employment?

If you are rehired within 30 days, you must either continue the same elections when you return or decline to participate in the Plan, unless one of the events permitting a change in election during the Plan Year has occurred.

If you are rehired at a later date, you must complete a new Enrollment Form if you wish to participate in the Plan.

11. When does my Participation in the Plan end?

Your participation will end if:

- You elect not to participate;
- You no longer satisfy the eligibility requirements for the Plan;
- You fail to pay contributions required by the Plan;
- You terminate employment with the Employer (there are special rules for terminating employees); or
- The Plan is terminated or amended to exclude you from eligibility.

LEAVES OF ABSENCE

1. What happens if I take an unpaid leave that is covered under the Family Medical Leave Act ("FMLA leave")?

If you go on a qualifying unpaid FMLA leave you may revoke your health coverage or continue your health coverage by making required payments. The Employer may continue health coverage by paying the Employer's and Employee's share of the contributions. Your Employer's policy for non-FMLA leaves will apply to non-health Benefits.

2. If I continue my health coverage during FMLA leave how much am I required to pay?

You pay the same amount that you would pay if you were working. If you are receiving payments during the FMLA leave, such as vacation pay, your payments for this Plan will be deducted on a pre-tax basis from those payments. If your leave is unpaid, the Plan Administrator will tell which of the following options you can use to make your payments:

- **Prepayment Option.** Under this option you make your contributions for your Benefits prior to your leave. These payments may be made on a pre-tax basis if pre-leave Compensation is available.
- **Pay-As-You-Go-Option.** Under this option you make after-tax contributions for your Benefits on the same schedule as Participants who are not on leave.
- **Catch-Up Option.** Under this option you pay for your Benefits when you return from FMLA leave. Payments may be made on a pre-tax basis if you have Compensation available.

3. Do I have to continue all Benefits during FMLA leave?

No. You may choose which Benefits you want to continue during your FMLA leave, or drop coverage for all Benefits.

4. What happens if I drop coverage for Benefits during my FMLA leave?

You may start your Benefits again when you return to work. You may also choose to discontinue Benefits for the remainder of the Plan Year. However, you cannot

otherwise change your Enrollment during or upon returning from FMLA leave unless you experience an event allowing an election change.

5. What happens if I take personal leave which is not an FMLA leave?

The answer depends on whether you are taking a paid leave or an unpaid leave:

- If you are taking a paid leave, your payments for this Plan will continue to be deducted on a pre-tax basis.
- If you are taking an unpaid leave that does not affect your eligibility you will continue to participate and will need to pay your contributions 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 Plan Administrator.
- If you are taking an unpaid leave that affects your eligibility, the rules that apply to your change of elections during the Plan Year will apply.

6. What are my rights to coverage under the Plan while I am on military service leave?

Your right to continue participation in the Plan for health Benefits during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). To continue health Benefits, you will be responsible for continuing payments. You may continue coverage for the lesser of 24 months or until one day after the date you apply for or return to employment in accordance with USERRA.

For a leave of 30 or fewer days, you will be charged the normal Employee share of the health premium. For a leave of 31 days or longer, you may be required to pay the full health premium (plus administrative charges) for coverage in the same manner as COBRA coverage.

When you return to employment within the time periods specified in USERRA, you may have health Benefits reinstated if you did not maintain coverage during your leave.

You may also continue or reinstate non-health Benefits as allowed by the Employer for other types of leaves.

PREMIUM BENEFITS

1. What are Premium Benefits?

If you are eligible, you can elect to make pre-tax contributions for your coverage under an eligible Employer provided plan.

2. Can I change my election for Premium Benefits during the Plan Year?

There are a number of events which may allow you to change your Enrollment mid-year:

- You may change your Enrollment if there is a "Change in Status" and the change you make complies with the "Consistency Rule."
- You may change your Enrollment if there is a "Cost Change" or "Coverage Change."
- You may change your Enrollment for "Other Events," which are generally based on legal requirements.

Any change in election must also be permitted by the Underlying Plan.

3. What is a Change in Status?

A "Change in Status" is one of the events listed below:

- Change in legal marital status. Events that change your marital status, including: marriage, divorce, legal separation or annulment.
- Change in number of Dependents. Events that change your number of Dependents, including: birth, death, adoption and placement for adoption.
- Change in Dependent eligibility. Events which cause your Dependent to satisfy or cease to satisfy the requirements for coverage due to reaching a specific age, student status, or any similar circumstance.
- Change in residence. A change in the residence of you, your spouse or your Dependent that affects eligibility for coverage under the Plan.

- Change in employment status. Events that change the employment status of you, your spouse or your Dependent, such as:
 - Termination or commencement of employment.
 - Beginning or returning from an unpaid leave.
 - Change in worksite.
 - Change in employment status so that an individual becomes (or ceases to be) eligible for a plan.

4. What is the Consistency Rule?

Whenever a Change in Status event occurs, the event must result in you, your spouse or a Dependent losing or gaining eligibility for coverage. Any election change you make:

- Must be on account of the Change in Status; and
- Must correspond with the Change in Status.

5. What options are available in the event of a Cost Change?

In the event you experience an insignificant increase or decrease in the cost of your contribution for an Employer plan, the Plan Administrator may adjust your election automatically without having to change your Enrollment. If the Plan Administrator determines that an increase in cost is significant you may be provided options including:

- Increasing or decreasing the amount you pay for coverage;
- Choosing another Benefit Option, (e.g., an HMO option) providing similar coverage which is offered by your Employer; or
- If there is no Benefit Option providing similar coverage, you may drop coverage.

If the Plan Administrator determines a decrease in cost is significant, you may elect the Benefit Option with the decreased cost (even if you have made no previous election under the Plan).

6. What options are available in the event of a Coverage Change?

If you experience a significant cutback in coverage, as determined by the Plan Administrator, you may make a new election if your Employer provides a Benefit Option providing similar coverage.

If you experience a loss of coverage:

- You may choose another Benefit Option providing similar coverage which is offered by your Employer; or
- If there is no Benefit Option providing similar coverage, you may drop coverage.

If the Plan Administrator determines that coverage options have significantly improved you may elect the newly added or significantly improved options.

7. What are Other Events permitting me to change my Enrollment for Premium Benefits mid-year?

You may make an election change which corresponds with any of the following Other Events:

- Legal Order. A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order, which requires health coverage for your child. You may not drop coverage for the child unless coverage is actually provided under another individual's plan.
- Medicaid or Medicare Enrollment. Enrollment by you, your spouse or your Dependent, under Medicare or Medicaid, (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act for distribution of pediatric vaccines). This event allows you to cancel or reduce your or the coverage of your Dependents, or you may commence or increase your coverage or the coverage of your Dependents if there is a loss for coverage under Medicare or Medicaid.
- Special Enrollment Rights Under HIPAA. Enrollment by you, your spouse or your Dependent, under a health plan's Special Enrollment Rights provisions. Special Enrollment Rights are required under the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA allows individuals to enroll in a health plan in special circumstances when an individual has gained a new Dependent or has lost eligibility for coverage under another plan.

- Medicaid/SCHIP Termination. Termination of coverage under Medicaid or under the State Children's Health Insurance Program ("SCHIP") due to loss of eligibility or eligibility for premium assistance in an employer group health plan under a Medicaid or SCHIP program.

8. When must I make an Enrollment Change?

If you are eligible to make a change in your election during the Plan Year, you must make your election within 30 days of the event permitting the change. You must make your election based on a Medicaid or SCHIP coverage change within 60 days of the event permitting the change.

HEALTH FLEXIBLE SPENDING ACCOUNT BENEFITS

1. What are Health Flexible Spending Account Benefits?

The Plan allows you to reduce your taxable income and use that amount to pay for uninsured Medical Expenses. Uninsured Medical Expenses are expenses that are not covered by insurance or other group benefits. You must be the only source of payment for the Medical Expenses.

Medical Expenses include amounts incurred for the diagnosis, care, mitigation, treatment or prevention of disease, affecting any structure or function of the body. Any transportation essential for the provision of medical care is considered a Medical Expense. Covered Medical Expenses also include prescription drugs. However, covered Medical Expenses do not include expenses incurred merely for the beneficial health of you or your Dependents rather than for therapeutic treatment of a medical condition. For instance, vitamins or dietary supplements that are not taken to treat a specific medical condition will not be covered by the Plan. Cosmetic surgery is not a covered Medical Expense and will not be reimbursed by the Plan. Covered Medical Expenses also do not include any premium paid for health coverage under any plan maintained by the Employer or any other employer or for long term care coverage.

Medical Expenses include, by way of example:

- Physical examinations;
- Eye examinations for the purpose of prescribing, fitting or changing eyeglasses or contact lenses;
- Eyeglasses and contact lenses;

- Obstetric and gynecological examination and care;
- Hospital services;
- Nursing services;
- Medical laboratory services;
- Surgery that serves a therapeutic purpose;
- Items and services in connection with the care, treatment, filling, removal or replacement of teeth;
- Orthodontia;
- Medical supplies (e.g., bandages, crutches, contact lens supplies, etc.);
- Prescription drugs;
- Over-the-counter medicine and drugs provided under a prescription by a medical provider (over-the-counter medicine and drugs, except insulin, are not reimbursable without a prescription);
- Psychiatric services;
- Artificial limbs;
- Ambulance hire; and
- Blood units.

Medical Expenses incurred by you and your Eligible Dependents described in Appendix A are covered expenses under this Plan.

2. During what period are Medical Expenses I incur reimbursable?

You may seek reimbursement for Medical Expenses incurred during the Plan Year and during any Grace Period following the end of the Plan Year specified in Appendix A below.

3. When is a Medical Expense "incurred"?

A Medical Expense is incurred when the Medical Care is provided, not when you are formally billed, charged or pay the expense. You cannot receive reimbursement for future or projected expenses.

4. How does participation in a high deductible Health Plan and Health Savings Account impact my ability to receive benefits under the Health Flexible Spending Account?

Limitations in benefits available are described in Appendix A below.

5. What Benefit limits apply?

Your Reduction Amount for Health Flexible Spending Account Benefits is limited to the maximum listed in Appendix A below.

6. What are my COBRA rights?

The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") is a federal law which allows you or your Dependents to continue coverage under a group health care plan after a "qualifying event" occurs:

- A qualifying event is an event which would cause you or your Dependent to lose health care coverage under the terms of the Plan.
- Qualifying events may include your death, your termination of employment or reduction of hours, your divorce or legal separation, your entitlement to Medicare, or a Dependent child's loss of Dependent status.

You must notify the Employer of a divorce, legal separation or a child losing Dependent status under the Plan within 60 days of the event or the date coverage is lost, whichever is later. For a divorce or legal separation, you must include a copy of the divorce decree or court order. To substantiate a child's loss of Dependent status, you must include proof of age or loss of full-time student status or other applicable documentation. You have 60 days from the date you would lose coverage for one of the reasons listed above or the date you are sent a notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage.

7. How does COBRA apply to Health Flexible Spending Account Benefits?

Health Flexible Spending Account Benefits are considered a separate group health plan and special COBRA rules apply.

- If your Plan qualifies as an excepted benefit under the COBRA regulations, COBRA will apply for the remainder of the Plan Year if you have "underspent" your Health Flexible Spending Account when the qualifying event occurs. Continuation of coverage under COBRA is not available to you if you did not underspend your Account.
- If your Plan does not qualify as an excepted benefit under the COBRA regulations, you may be eligible to continue coverage for up to 18 to 36 months depending on the qualifying event.

The Plan Administrator will tell you how long you may continue coverage under COBRA and will provide you a COBRA Election Form. You may elect COBRA coverage as provided on the Form.

8. What does "underspent" mean?

"Underspent" means that when the qualifying event occurs your unused Health Flexible Spending Account Benefits are greater than the COBRA amounts that you will be required to pay for Health Flexible Spending Account Benefits for the remainder of the Plan Year.

9. How much am I required to pay for COBRA coverage?

The cost is the cost of your coverage plus a 2% administrative charge.

10. Can I change my election for Health Flexible Spending Account Benefits during the Plan Year?

- You may change your Enrollment if there is a "Change in Status" and the change you make complies with the "Consistency Rule."
- You may change your Enrollment for "Other Events," which are generally based on legal requirements.
- You **cannot** change your Enrollment if there is a "Cost Change" or "Coverage Change."

11. What is a Change in Status?

A "Change in Status" is one of the events listed below:

- Change in legal marital status. Events that change your marital status, including: marriage, divorce, legal separation or annulment.
- Change in number of Dependents. Events that change your number of Dependents, including: birth, death, adoption and placement for adoption.
- Change in Dependent eligibility. Events which cause your Dependent to satisfy or cease to satisfy the requirements for coverage due to reaching a specific age, student status, or any similar circumstance.

- Change in residence. A change in the residence of you, your spouse or your Dependent that affects eligibility for coverage under the Plan.
- Change in employment status. Events that change the employment status of you, your spouse or your Dependent, such as:
 - Termination or commencement of employment.
 - Beginning or returning from an unpaid leave.
 - Change in worksite.
 - Change in employment status so that an individual becomes (or ceases to be) eligible for a plan.

12. What is the Consistency Rule?

Whenever a Change in Status event occurs, the event must result in you, your spouse or a Dependent losing or gaining eligibility for coverage. Any election change you make:

- Must be on account of the Change in Status; and
- Must correspond with the Change in Status.

13. Can I "carry over" unspent funds?

No. Under the "use-it-or-lose-it" rule that applies to Cafeteria plans, salary Reduction Amounts made in one Plan Year cannot be used in a subsequent Plan Year except for any Grace Period Specified in Appendix A below.

14. Can I receive qualified reservist distributions?

Any ability to receive qualified reservist distributions under the Plan is specified in Appendix A.

15. How do I submit a claim for reimbursement?

You will be reimbursed for your eligible uninsured Medical Expenses by submitting your completed claim form to the Claims Administrator. Your claim for Benefits must include:

- The amount and date of each expense;

- The name of the person, organization or company to which the expense was paid;
- The name of the person for whom the expense was incurred and, if that person is not the Participant in the Plan, the relationship of the person to the Participant;
- The amount recovered or expected to be recovered for that expense under any insurance arrangement or other plan;
- A statement that the expense (or the portion of the expense for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage. If the expense is insurable, the Participant must provide an explanation of benefits ("EOB");
- Any bills, invoices, receipts, canceled checks or other statements showing the amount of the expense; and
- Any other information required by the Claims Administrator.

If you have additional questions, contact the Claims Administrator, or see Internal Revenue Service Publication 502, *Medical and Dental Expenses*.

16. What rules apply if I submit claims for reimbursement through a debit card?

If you use a debit or stored card for payment of Medical Expenses, you must comply with the rules for the card established by the Claims Administrator, including the following rules:

- You must enter into a written agreement to certify:
 - that your card will only be used for Medical Expenses that have been incurred;
 - that any Medical Expense you pay with the card will not have been already reimbursed by any other plan covering health benefits;
 - that the you will not seek reimbursement from any other plan covering health benefits; and
 - that you will obtain and maintain sufficient documentation for Medical Expenses you pay with the card.
- A card will only be issued to you upon your participation in the Health Flexible Spending Account Benefits. The card will be automatically cancelled upon

your death or termination of employment, if you are no longer enrolled in the Health Flexible Spending Account Benefits or you withdraw due to a change in status, or if you use the card for impermissible expenses.

- The dollar amount of coverage available on the card is the amount you elected for the Plan Year.
- Use of the card is limited to medical care providers and certain stores allowed under IRS guidance for card payments of Medical Expenses.
- Your use of the card for Medical Expenses is subject to substantiation to the Claims Administrator, usually by submission of a receipt from a medical provider or certain stores describing the product or service, the date and the amount. All charges are conditional pending confirmation and substantiation. Submission of receipts for card payments is not required for Medical Expenses that are substantiated copayment matches, certain recurring Medical Expenses, real-time substantiation of Medical Expenses at the time of sale and Medical Expenses substantiated through an inventory information approval system if the IRS requirements for these types of substantiations are satisfied.
- If you fail to provide the Claims Administrator with requested substantiation for a Medical Expense or if your card purchase is later determined by the Claims Administrator to not qualify as a Medical Expense, the Claims Administrator and/or Employer, in its discretion, will use one or more of the following correction methods to make the Plan whole:
 - deactivate the card until the amount of the improper payment is recovered;
 - require you to repay the improper amount;
 - if you fail to repay the improper amount, withhold the improper payment from your wages or other compensation to the extent permitted by applicable federal or state law;
 - if the amount remains unpaid, offset future claims until the amount is repaid; and
 - if the amount continues to remain unpaid, treat the improper payment as a debt you owe to the Employer.

17. What is the deadline for submitting claims for reimbursement?

You must submit all claims for reimbursement within the timeframe specified in Appendix A. No claims submitted after that time will be reimbursed.

18. When will I find out if my claim for Health Flexible Spending Account Benefits has been approved or denied?

The Plan Administrator will notify you within 30 days from the date your claim was received if it has been approved, denied, or if additional information is required. The 30-day period can be extended to 45 days under certain circumstances.

If the Plan Administrator requests more information, you will be given at least 45 days from the date of notice to provide the specific information. If you submit the additional information within the 45-day (or longer) period, the Plan Administrator will notify you of the claims determination within 15 days from the date the Plan Administrator received the additional information.

19. What happens if my claim for Health Flexible Spending Account Benefits is denied?

If your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

- The reason(s) why the claim or a portion of it was denied;
- Reference to Plan provisions on which the denial was based;
- If the denial was based on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol. The information will be provided free of charge;
- What additional information, if any, is required to perfect the claim and why the information is necessary; and
- What steps you may take if you wish to appeal the decision, and a statement that after you follow the Plan's internal review process for your appeal, you may file an action in federal court under Section 502 of ERISA, if you disagree with the Plan's decision on the appeal.

20. How do I appeal a denial of Benefits?

If you dispute a denial of benefits, you may file an appeal within 180 days of receipt of the denial notice. This appeal must be in writing and must contain the following information:

- Your name and address;
- Your reasons for making the appeal; and
- The facts supporting your appeal.

The appeal will be answered in writing within 60 days, stating whether it has been granted or denied. The claim review will be subject to the following rules:

- The claim will be reviewed by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial denial nor a subordinate of that individual.
- The review will be conducted without giving deference to the initial denial.

21. What happens if my appeal is denied?

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

- The specific reasons for the appeal denial.
- Reference to the specific Plan provisions on which the denial is based.
- A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits. The information will be provided to you without charge.
- If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol. The information will be provided to you without charge.
- A statement regarding your right to bring an action under Section 502(a) of ERISA.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described under these claims procedures. If any of the claims procedures outlined above are not followed, you will be deemed to have exhausted the opportunities described under these procedures and may pursue legal action at any time. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, you are not satisfied with the result, then you must file any legal action within 180 days of receiving the final review notice under these procedures.

22. Do additional rules and rights apply under the Patient Protection and Affordable Care Act (PPACA)?

Any additional rights and rules under PPACA are described in Appendix A below.

23. What are my rights under ERISA?

Plan Participants who have Health Flexible Spending Account Benefits are entitled to certain rights and protections pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Employer and Plan Administrator intend to comply fully with ERISA. If you have a question about the Plan, how it is run and how it affects you, you should contact the Plan Administrator.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan Participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

DEPENDENT CARE REIMBURSEMENT ACCOUNT BENEFITS

1. What are Dependent Care Reimbursement Account Benefits?

The Plan allows you to reduce your taxable income and use that amount to pay all or part of your Dependent Care Expenses. Dependent Care Expenses are the expenses you incur for the care of a Dependent so that you or your spouse can be employed.

2. What are Dependent Care Expenses?

- Dependent Care Expenses include amounts paid to persons who provide care for Dependents. Expenses most likely to qualify are day care centers, nurseries, babysitters and companions for Dependents who are incapable of caring for themselves.
- Education or the transportation costs for a Dependent are not eligible Dependent Care Expenses. The purchase of tangible goods also does not qualify as an eligible Dependent Care Expense.
- Please note that you cannot receive reimbursement for Dependent Care Expenses under this Plan and receive a tax credit for federal taxes for the same expenses. Also, the reimbursement of Dependent Care Expenses under this Plan reduces the amount of Dependent Care Expense eligible for the tax credit. Please consult a tax advisor to determine which option would be best for you.

3. Who are Dependents?

Dependent Care Expenses will be covered for the care of the following Dependents:

- A child under the age of 13 whom you claim as a Dependent for federal income tax purposes;
- Your Dependent for federal income tax purposes who is physically or mentally unable to care for herself or himself; or
- Your spouse if the spouse is physically or mentally unable to care for herself or himself.

If you were divorced, legally separated, or lived apart from your spouse during the last 6 months of a calendar year, you may be able to claim reimbursement for Dependent Care Expenses under the Plan even if you do not claim the child as a Dependent for federal income tax purposes.

If you have additional questions, contact the Claims Administrator or see Internal Revenue Service Publication 503, *Child and Dependent Care Expenses*.

4. Does my spouse have to be employed?

For expenses to be treated as Dependent Care Expenses, your spouse (if you are married) generally must be employed. However, if your spouse is incapacitated or is a full-time student, the expenses to care for your Dependents may be considered eligible Dependent Care Expenses.

5. Who can provide dependent care?

Generally, any individual or dependent care center may provide dependent care services which qualify as Dependent Care Expenses. However, dependent care may not be provided by:

- A Dependent of the Participant;
- The Participant's spouse; or
- A child of the Participant under age 19 at the end of the year in which expenses are incurred.

Dependent care can be provided in or outside of your home. However, the dependent care provided outside your home is limited to a Dependent who is:

- A child under the age of 13 whom you claim as a Dependent for federal income tax purposes; or
- Any individual who is defined as a Dependent by this Plan and who spends at least eight hours a day in your home.

In addition, if you send a Dependent to a day care center that cares for more than six individuals, that day care center must comply with all applicable state and local laws.

6. What Benefit limits apply?

You are limited to the Reduction Amount which you elect in your Enrollment election for Dependent Care Reimbursement Account Benefits. The Reduction Amount cannot exceed the lesser of either your or your spouse's yearly earnings. Also, the total Dependent Care Reimbursement Account Benefits provided under this Plan during the Plan Year or calendar year to a participant cannot exceed \$5,000. (A married participant filing separately is limited to a benefit of \$2,500.)

If you are eligible for Dependent Care Reimbursement Account Benefits because your spouse is a full-time student or is incapacitated, there are additional limits. In those cases, Benefits are limited to:

- \$250 a month if there is only one Dependent; or
- \$500 a month if there is more than one Dependent.

7. During what period are Dependent Care Expenses reimbursable?

Dependent Care Expenses are incurred when the services are provided and not when you are billed, charged or pay for the Dependent Care Expenses. You may seek reimbursement for Dependent Care Expenses incurred during the Plan Year and during any Grace Period following the Plan Year specified in Appendix A below.

8. How do I submit a claim?

You will be reimbursed for your Dependent Care Expenses by submitting to the Claims Administrator the following information:

- The amount and date of the expense;
- The name and Social Security number or other taxpayer identification number of the person, organization or company to which the expense was paid; and
- Any bills, invoices, receipts or statements showing the amount of the expense.
- Any other information requested by the Claims Administrator.

Claims should be submitted on the proper form provided by the Claims Administrator.

9. What is the deadline for submitting claims for reimbursement?

You must submit all claims for reimbursement within the timeframe specified in Appendix A. No claims submitted after that time will be reimbursed.

10. Can I change my election for Dependent Care Reimbursement Account Benefits during the Plan Year?

There are a number of events which may allow you to change your Enrollment mid-year:

- You may change your Enrollment if there is a "Change in Status" and the change you make complies with the "Consistency Rule."
- You may change your Enrollment if there is a "Cost Change" or "Coverage Change."
- You may change your Enrollment for "Other Events," which are generally based on legal requirements.

11. What is a Change in Status?

A "Change in Status" is one of the events listed below:

- Change in legal marital status. Events that change your marital status, including: marriage, divorce, legal separation or annulment.
- Change in number of Dependents. Events that change your number of Dependents, including: birth, death, adoption and placement for adoption.

- Change in Dependent eligibility. Events which cause your Dependent to satisfy or cease to satisfy the requirements for coverage due to reaching a specific age, student status, or any similar circumstance.
- Change in residence. A change in the residence of you, your spouse or your Dependent that affects eligibility for coverage under the Plan.
- Change in employment status. Events that change the employment status of you, your spouse or your Dependent, such as:
 - Termination or commencement of employment.
 - Beginning or returning from an unpaid leave.
 - Change in worksite.
 - Change in employment status so that an individual becomes (or ceases to be) eligible for a plan.

12. What is the Consistency Rule?

Whenever a Change in Status event occurs, the event must result in you, your spouse or a Dependent losing or gaining eligibility for coverage. Any election change you make:

- Must be on account of the Change in Status; and
- Must correspond with the Change in Status.

13. Can I change my election if the cost changes?

Yes, if the person providing Dependent care is not a relative. Please contact the Plan Administrator for a list of individuals who are considered "relatives" for purposes of Dependent Care Reimbursement Account Benefits.

14. What options are available in the event of a Coverage Change?

You can change your election if your need for Dependent Care Reimbursement Account Benefits changes.

15. Can I "carry over" unspent funds?

No. Under the "use-it-or-lose-it" rule that applies to Cafeteria plans, salary reduction contributions made in one Plan Year cannot be used in a subsequent Plan Year except for any Grace Period specified in Appendix A below.

16. What if I terminate my employment during the Plan Year?

You cannot receive reimbursements for more than you have contributed to your Dependent Care Reimbursement Account at any time. If you have amounts in your Dependent Care Reimbursement Account that are unused as of termination of employment, you can request reimbursements up to that amount for eligible Dependent Care Expenses incurred during the remainder of the Plan Year.

APPENDIX A ADDITIONAL PLAN INFORMATION

1. Benefits offered in this Plan.

This Plan offers the following types of Benefits:

- Premium Benefits allow you to pay your contributions to eligible plans provided by the Employer with pre-tax dollars.
- Health Flexible Spending Account Benefits allow you to pay uninsured medical expenses with pre-tax dollars.
- Dependent Care Reimbursement Account Benefits allow you to pay dependent care expenses with pre-tax dollars.

2. Eligibility requirements for participation in the Plan.

Eligibility for participation in this Plan is limited to the following classes of Employees:

Only employees who work a minimum of 0 hours per week are eligible to participate in the plan.

Participation in the Plan begins 30 days from date of hire.

3. Deemed elections for Employees who fail to return an Enrollment Form.

Employees who fail to return a validly completed Enrollment Form, either during an Initial Enrollment Period or during an Open Enrollment Period, will be deemed to have made the following elections:

- It will be assumed that the Employee wants to participate in the Premium Benefits to pay for contributions for eligible Employer-provided plans on a pre-tax basis. A renewal of Enrollment will be adjusted for any increase or decrease in the contribution amounts.
- It will be assumed that the Employee does not want to participate in any other Benefits.

4. Eligible Dependents for Health Flexible Spending Account Benefits.

You may receive reimbursement for Medical Expenses under the Health Flexible Spending Account Benefits for anyone who qualifies as an eligible Dependent under IRS regulations. This includes but is not limited to your lawful spouse and child, legally adopted child, child placed for adoption, step-child, and a child who is an alternate recipient under a qualified medical child support order. Coverage generally continues up to the end of the year in which a child attains age 26 and may continue beyond the date for a child who is physically or mentally disabled. You can contact the Claims Administrator with specific questions about Dependent eligibility.

5. Limited Benefits for Health Flexible Spending Account Benefits.

In the event you are covered by a high deductible Health Plan and you elect to be covered by a Limited Health Flexible Spending Account to enable you to make contributions to a Health Savings Account, you may not receive reimbursement for any Medical Expense until you have satisfied the deductible of your high deductible health plan. This means that your Health Flexible Spending Account will be unavailable for reimbursement of any expenses that fall within your applicable deductible. There are some limited exceptions. One exception to this rule is that you may receive reimbursement for Medical Expenses for preventative care, if such care is otherwise covered under the terms of this Health Flexible Spending Account.

6. Maximum reductions for Benefits.

The maximum benefit for the Health FSA is \$4000.

7. Grace Period for incurring reimbursable expenses.

Unused benefits or contributions of employees can be paid or reimbursed to plan participants for qualified benefit expenses incurred through 3/15.

8. Time period for submitting claims.

Participants who terminate mid-year have 30 days from the date of termination to submit eligible services incurred prior to date of termination. Otherwise, you have 119 days from the end of the plan year to submit claims for services incurred within the plan year.

9. PPACA Rights and Requirements

The PPACA may define your plan as (1) a Plan that is an excepted benefit plan and not subject to PPACA; (2) a Plan that is not an excepted benefit plan, but is grandfathered under PPACA; or (3) a Plan that is subject to PPACA. Please follow the option that pertains to your Plan.

Option 1: This Plan qualifies as an excepted benefit plan and is not subject to additional rights and requirements under the Pension Protection and Affordable Care Act ("PPACA").

Option 2: This Plan is not an excepted benefit plan but is grandfathered under PPACA.

Notice of Grandfathered Health Plan Status

The Employer believes the Plan qualifies as a “grandfathered health plan” under the Patient Protection and Affordable Care Act ("PPACA"). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Option 3: This Plan is subject to PPACA

The following additional requirements apply to the Health Flexible Spending Account Benefits as required by the Patient Protection and Affordable Care Act ("PPACA"):

- A rescission of coverage will be treated as a claim denial and subject to all of the rules and requirements of a claim denial;

- Written or electronic notices to you must be provided in a culturally and linguistically appropriate manner as required by PPACA;
- Notice of a claim denial must also include information sufficient to identify the claim involved, any denial codes and their corresponding meaning, the standard used in denying the claim, what steps you may take for external appeal of the decision and the availability of and contact information for, an applicable office of health insurance customer assistance or ombudsman;
- In the event you submit a claims appeal, you will be permitted to present evidence or testimony relating to the claim;
- In the event the Administrator relies on, considers or generates new additional evidence relevant to a claim, the Administrator must provide you with that information, free of charge, sufficiently in advance of the due date of the notice of final adverse benefit determination to give you reasonable opportunity to respond. If a final adverse benefit determination is based on new or additional rationale, the Administrator must provide you the rationale sufficiently in advance of the due date of the notice of final adverse benefit determination to give you a reasonable opportunity to respond;
- The Administrator must ensure that all claims are adjudicated in a manner to ensure the independence and impartiality of the persons involved in making the decision.

You may file a request for external review with the Administrator, provided that the request is filed within four months after the date of receipt of final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of the notice, the request must be filed by the first day of the fifth month following receipt of notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next business day.

Within five business days following the date of receipt of the external review request, the Administrator will complete a preliminary review of the request to determine whether (1) you are or were covered under the Plan at the time the health care item or service in question was provided; (2) the adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan; (3) you have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process; and (4) you have provided all the information and forms required to process the external review.

Within one day after completion of the preliminary review, the Administrator will issue you a notification in writing. If the request is complete, but not eligible for external review, the notice must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Administrator will allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

In the event the Administrator determines that your request for external review is valid, the Administrator will assign an Independent Review Organization (IRO) that is accredited by URAC or by similarly nationally-recognized crediting organizations to conduct the external review. The Administrator will take action against bias and ensure independence. In this regard, the Administrator will contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support denial of benefits.

The contract between the Plan and the IRO will include the terms that are required by regulations under PPACA.

In the event of a notice of final external review decision reversing the adverse benefit determination, the Plan will provide immediate authorization for payment of the claim.