SUMMARY PLAN DESCRIPTION

OF THE

LTX, Inc.
FLEXIBLE BENEFITS PLAN

Effective 1/1/2015

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INTRODUCTION

Your employer, LTX, Inc. ("Employer"), is pleased to sponsor an employee benefit program known as the LTX, Inc. Flexible Benefits Plan (the "Plan") for its employees. Under federal tax laws, it is also known as a "cafeteria plan." The Employer provides you with the opportunity to use pre-tax dollars to pay certain benefit costs by entering into a salary reduction arrangement. This arrangement helps you because many of the benefits you elect are nontaxable; you should save social security and income taxes on the amount of your salary reduction.

This summary describes the basic features of the Flexible Benefits Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Flexible Benefits Plan, and a brief description of your rights as a Participant. To make use of this Flexible Benefits Plan, be sure to proceed through this booklet carefully so that you can make informed decisions that are right for you.

If there is a conflict between the underlying Plan and this summary, the intention is for the Flexible Benefits Plan documents to govern.

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Flexible Benefits Plan?

The purpose of the Flexible Benefits Plan is to allow eligible employees to use funds provided through employee salary reduction and Employer Contributions (if any) to choose (and pay for) certain benefits made available by the Employer.

1.2 When did the Flexible Benefits Plan take effect?

This Plan originally became effective 1/1/2009. This restatement is effective 1/1/2015. The Plan operates on a Plan Year running from January 1 - December 31.

1.3 What Optional Benefits are offered through the Flexible Benefits Plan?

This Plan makes the following "Optional Benefits" available:

Non-Reimbursement:

- Group Medical Benefits
  - The group medical benefit allows a Participant to pay the employee's share of the cost for medical coverage made available by the Employer with pre-tax dollars through salary reduction and Employer Contributions (if any).
- Group Dental Benefits
  - The group dental benefit allows a Participant to pay the employee's share of the cost for dental coverage made available by the Employer with pre-tax dollars through salary reduction and Employer Contributions (if any).

Reimbursement:

- Dependent Care Expense Reimbursement Plan
  - The dependent care reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction and Employer Contributions (if any) that may be used to reimburse the Participant for eligible dependent care expenses.
- Medical Expense Reimbursement Plan
  - The medical expense reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction and Employer Contributions (if any) which may be used to reimburse the Participant for eligible medical expenses.
- Individual Premium Feature
  - The individual premium feature allows a Participant to pay the employee's share of the cost of certain individual insurance policies with pre-tax dollars through salary reduction and Employer Contributions (if any).

1.4 Who can participate in the Flexible Benefits Plan?

Each employee who (a) is employed thirty-two (32) hours or more per week, and (b) has been employed by the Employer for ninety (90) days is eligible to participate in the Flexible Benefits Plan. These employees are called "Eligible Employees." Those Eligible Employees who actually participate in the Flexible Benefits Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of the exceptions.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" also does not include any individual deemed by the Internal Revenue Code to be self-employed, such as partners, shareholders of S-corporations who own more than 2% of the corporation's stock and members of their families, and (in most cases) members of limited liability corporations. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

1.5 When do I become a Participant and how long does participation last?

For newly eligible Employees, participation may begin on the date on which you satisfy the definition of Eligible Employee or, if later, the first day of the first pay period following your completion and submission of any required enrollment forms. If they are required to begin participation, you must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator.

NOTE: With respect to Group Medical Benefits, Group Dental Benefits, if you have enrolled in those benefits, you may automatically become a Participant in this Flexible Benefits Plan as described in Section 1.6.

A special rule applies to new hires. Notwithstanding the foregoing, if you enroll within 30 days following your date of hire, your enrollment will be effective as of your date of hire. Any salary reduction contributions covering this retroactive coverage period will be taken from compensation earned after you complete and submit the enrollment forms.

If you do not become a Participant when first eligible, you may become a Participant at the start of any subsequent Plan Year.

As a condition to participation in the Flexible Benefits Plan, you must also:

(a) observe all Plan rules and regulations;

(b) agree to inquiries by the Employer with respect to any physician, hospital, or other provider of medical care or other services covered by this Flexible Benefits Plan;

(c) submit to the Employer all notifications, reports, bills, and other information that the Employer may reasonably require; and

(d) agree to repay any overpayments or incorrect payments you receive from the Flexible Benefits Plan.

Participation continues until you elect not to participate, you are no longer an Eligible Employee, the Flexible Benefits Plan terminates, your contributions cease, or your participation is terminated for cause.

1.6 How do I enroll and make benefit elections?

(a) **Generally**. The Plan Administrator will provide you with the forms necessary to enroll and make elections, including information about the costs of the various Optional Benefits.

(b) **Initial Enrollment**. If you become an Eligible Employee other than at the start of a Plan Year, the initial enrollment period for the Flexible Benefits Plan takes place at the time you become eligible to participate as described in Section 1.5. If you do not make an election during the initial enrollment period, you must wait until the next annual enrollment period to begin participation. However, if you have enrolled in the Group Medical Plan, Group Dental Plan, you will be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible under such plans.

(c) **Annual Enrollment**. The annual enrollment period for the coming Plan Year begins and ends on or before the last day of each Plan Year. If you do not make an election during the annual enrollment period, you will be deemed to have elected to not participate in the Flexible Benefits Plan. However, if you have enrolled in the Group Medical Plan, Group Dental Plan, you will be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible under such plans.

NOTE: Enrollment forms received after the close of the enrollment period shall be void.

CAUTION: With limited exceptions, once made, elections remain in effect for the entire Plan Year. The exceptions are described below at Question 1.8.

1.7 What is the maximum election I can make under the Flexible Benefits Plan?

The maximum election available under this Flexible Benefits Plan is the sum of the employee portion of the cost of coverage under the [the Group Medical Plan, Group Dental Plan, Group Term Life and AD&D Plan, and the maximum election permitted under the Medical Expense Reimbursement Plan, Limited Scope Medical Expense Reimbursement Plan, Dependent Care Expense Reimbursement Plan, and the HSA Contribution Feature – as applicable.

1.8 Can I change my election during Plan Year?

Generally, you cannot change your election regarding participation in the Flexible Benefits Plan or the benefits you have selected during the Plan Year. You may change your elections only during the annual enrollment period, and then, only for the coming Plan Year. However, your elections will terminate automatically if you cease to be eligible to participate in the Flexible Benefits Plan. In addition, there are several other exceptions to this general rule.

Caution: The circumstances in which you are allowed to change your election, as further described below, are based upon the facts and circumstances of each particular situation. The descriptions of the rules below are general in nature. If you have questions regarding the application of the rules to your specific fact situation, please contact the Plan Administrator immediately. Any request to change your election must be within the deadline described below.

NOTE: The exceptions to the general rule that elections are irrevocable for the Plan Year are determined under regulations issued by the IRS.

NOTE: The IRS recognizes only marriages between persons of the opposite sex that are valid under applicable state law. Accordingly, a reference to marital status or spouse in this Section 1.8 is applicable only if you are married to an individual of the opposite sex and the marriage is valid under applicable state law.

NOTE: For purposes of this Section 1.8, if the election relates to an Optional Benefit involving health benefits (e.g., Group Medical Plan, Group Dental Plan, Medical Expense Reimbursement Plan), the term "dependent" means a "tax dependent" as defined below in Section 1.16. If the election relates to the Dependent Care Expense Reimbursement Plan, the term "dependent" means a "qualifying individual" as defined below in Section 3.5.

(a) **Change in Status.** You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

(1) a change in your legal marital status, including marriage, divorce, death of your spouse, legal separation or annulment;

NOTE: A change in the status of a domestic partnership is not a change in status.

(2) a change in the number of your dependents, including birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;

(3) any of the following events that change your employment status or the employment status of your spouse or dependent: termination or commencement of employment, a reduction or increase in hours worked, a switch between part-time and full-time, a strike or lockout, a change in worksite, commencement or return from an unpaid leave of absence, a switch between hourly and salaried, a switch between union and non-union, or any similar event;

(4) an event causing a dependent to satisfy or cease to satisfy the eligibility requirements applicable under a plan provided or paid for through this Flexible Benefits Plan; or

(5) a change in place of residence for you, your spouse or your dependent.

A change or revocation shall be allowed in these circumstances only if such change or revocation is made on account of, and corresponds with, the change in status and the change in status affects eligibility for coverage under a plan sponsored by the Employer or another employer (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change or revocation satisfies the general consistency requirement.

Example 1: An employee enrolls in single coverage under the Employer's Group Medical Plan and elects to pay the cost of that coverage through the Flexible Benefits Plan. The employee also elects to participate in the Medical Expense Reimbursement Plan. During the Plan Year, the employee gets married. If the employee enrolls his or her new spouse in the Group Medical Plan, the employee may change his or her election to pay the increased cost of that coverage through the Flexible Benefits Plan. In addition, the employee may increase his or her election under the Medical Expense Reimbursement Plan.

Example 2: Employer has three medical plan options: an indemnity option, an HMO option with a service area covering the location of one of Employer's operations, and an HMO option with a service are covering the location of the other operation. An employee enrolls in the HMO option with a service area covering the area in which employee works and makes an election to pay the cost of the coverage through the Flexible Benefits Plan. Employee also elects to participate in the Medical Expense Reimbursement Plan. If employee is transferred to the other location, the employee may switch to the other HMO option or the indemnity option and change his or her election to pay the cost of the new option. The employee may also drop medical coverage and terminate his or her election under the Flexible Benefits Plan to pay the cost of medical coverage. The employee cannot change his or her election under the Medical Expense Reimbursement Plan because the change in work location does not affect his or her eligibility under the Medical Expense Reimbursement Plan.

A requested change or revocation must also satisfy the following specific consistency requirements in order for you to be able to alter your election based on the change in status:

(1) **Loss of Dependent Eligibility.** For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, you may elect to change your election only to reflect the cancellation of group health plan coverage for the affected spouse or dependent. Canceling coverage for any other individual under these circumstances fails to correspond with that change in status. For example, if you have elected group medical coverage for you, your spouse, and your child, and you divorce during the Plan Year, you may drop your ex-spouse from the coverage and make an election change under this Flexible Benefits Plan to reflect the reduced cost of coverage. However, you would not be allowed to change your election to reflect the reduced cost attributable to dropping coverage for yourself or your child.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. If you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in employment status, you may elect to terminate or decrease your election under this Flexible Benefits Plan on account of that change in status only if coverage becomes effective or is increased under the other employer's plan.

(3) **Dependent Care Expense Reimbursement Plan**. With respect to the Dependent Care Expense Reimbursement Plan, you may change or terminate your election only if (i) the change or termination is made on account of and corresponds with a change in status that affects eligibility for coverage under the Flexible Benefit Dependent Care Expense Reimbursement Plan; or (ii) the election change is on account of and corresponds with a change in status that

affects eligibility of dependent care expenses for the tax exclusion available under the Internal Revenue Code. For example, if your child attains age 13 during the Plan Year, you may terminate your election under the Dependent Care Expense Reimbursement Plan because your child is no longer eligible to participate in the Dependent Care Expense Reimbursement Plan (i.e., she is no longer a qualifying individual).

(4) **COBRA Coverage**. If you, your spouse, and/or your dependent elects COBRA continuation coverage (or similar health plan continuation coverage under state law) with respect to a group health plan sponsored by the Employer, you may increase your election for the purpose of paying the cost of the increased premium for such continuation coverage, provided you are still eligible under the Flexible Benefits Plan and are receiving compensation from the Employer.

(b) **Other Change in Election Events.** You may also change or revoke your previous election during the Plan Year in the following circumstances.

(1) **HIPAA Special Enrollment Rights**. In certain cases, individuals are allowed to enroll in the Employer's Group Medical Plan pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (i) acquiring a new spouse or dependent, (ii) loss of other group coverage, (iii) loss of coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (iv) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan. (Please refer to the plan documentation for the Group Medical Plan for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under that plan.).

If you, your spouse, and/or your dependent actually enroll in the Group Medical Plan pursuant to HIPAA special enrollment, then you may make a new election under the Flexible Benefits Plan to pay the cost of that new or increased coverage. For purposes of this provision an election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right.

Note: There are two separate steps involved in making an election change under this exception. You must enroll in the Group Medical Plan within the HIPAA special enrolment time period required under that plan. You must also request a change to your election under the Flexible Benefits Plan in accordance with paragraph (c) below. The time period described in paragraph (c) begins to run on the effective date of your coverage under the Group Medical Plan. It is the coverage attributable to the HIPAA special enrollment that triggers the need to change election under the Flexible Benefits Plan.

To the extent the Medical Expense Reimbursement Plan is subject to HIPAA special enrollment, these same rules apply.

(2) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires you to cover your child (including a foster child who is your dependent) under the

Group Medical Plan, Group Dental Plan, the Medical Expense Reimbursement Plan, you may change your election to pay the increased cost of coverage incurred to add the dependent child to your coverage. If an Order requires another individual to provide health coverage for your child (including a foster child who is your dependent) and the child is currently enrolled in the Group Medical Plan, Group Dental Plan, the Medical Expense Reimbursement Plan, you may terminate coverage for the child and change your election to reflect the reduced cost of coverage (if any), provided the other individual actually provides coverage to the child as required by the Order. For example, if you have enrolled in single coverage under the Group Medical Plan, become divorced during the Plan Year, and are ordered to provide coverage to your child following the divorce, you may increase your election to pay the additional cost of the child's coverage under the Group Medical Plan.

(3) **Medicare and Medicaid**. If you, your spouse, or your dependent is enrolled in the Group Medical Plan, Group Dental Plan, such individual subsequently enrolls in Medicare or Medicaid, and such individual's coverage under the Employer's plan is cancelled, you may change your election to reflect the reduced cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also reduce or cancel your election with respect to the Medical Expense Reimbursement Plan. Further, if you, your spouse, or your dependent has been enrolled in Medicare or Medicaid, such individual loses eligibility for such coverage, and such individual enrolls in the Group Medical Plan, Group Dental Plan, you may change your election to reflect the increased cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also make or increase your election with respect to the Medical Expense Reimbursement Plan.

(4) **Change in Cost**.

NOTE: Although the Plan Administrator will be aware of an increase or decrease in the cost of many Optional Benefits, you will need to notify the Plan Administrator of any changes to the cost of benefits under the Dependent Care Expense Reimbursement Plan and the Individual Premium Feature.

(i) **Automatic Increase or Decrease for Insignificant Cost Changes**. If the cost of coverage increases or decreases during a Plan Year by an insignificant amount, then your election to pay the cost of such coverage through the Flexible Benefits Plan shall be automatically increased or decreased to reflect such change in the cost. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(ii) **Significant Cost Increases**. If the Plan Administrator determines that the cost of coverage significantly increases during a Plan Year, you may either: (a) increase in your election to pay the additional cost, (b) enroll in another benefit package option providing similar coverage and change your election (if necessary) to pay the cost of that option through the

Flexible Benefits Plan, or (c) cancel the underlying coverage and revoke your election to pay the cost of that coverage through the Flexible Benefits Plan if no other benefit package option providing similar coverage is available. For example, if the cost of one option under the Group Medical Plan significantly increases during the Plan Year, you may increase your election to pay the increased cost or enroll in another option available under the Group Medical Plan and change your election to correspond to the new cost of Group Medical Plan coverage. If there is only Group Medical Plan option, you may increase your election to pay the increased cost of that option or cancel Group Medical Plan coverage and revoke your election to pay for that coverage through the Flexible Benefits Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(iii) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of coverage significantly decreases during a Plan Year: (a) you may enroll in the coverage and make or change your election to pay the cost of such coverage through the Flexible Benefits Plan; or (b) if you are already enrolled in the underlying coverage and are paying the cost of such coverage through the Flexible Benefits Plan, the Plan Administrator will automatically decrease your election to pay the cost of such coverage in accordance with the cost decrease.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(a) **Cause of Cost Changes.** For purposes of this rule, a change in cost allowing an election change can result from action taken by you (e.g., switching between full-time and part-time employment) or your employer (e.g., changing the amount of employer contribution toward the cost of coverage).

(b) **Application to Dependent Care Reimbursement Plan.** This rule does not apply to changes in cost if the dependent care provider is your relative.

(5) **Change in Coverage**.

(i) **Significant Curtailment**. If the Plan Administrator determines your coverage, or the coverage or your spouse or dependent, is significantly curtailed during a Plan Year, you may enroll in another benefit package option providing similar coverage and make a corresponding election change to pay for that new coverage through the Flexible Benefits Plan. Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to all participants in general (e.g., a significant increase in the deductible, copays, or out-of-pocket maximum applicable under the plan). The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(ii) **Loss of Coverage.** If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is lost during a Plan Year, you may: (i) enroll in another option providing similar coverage and make a corresponding election change to pay for that new coverage through the Flexible Benefits Plan, or (ii) if no other option providing similar coverage is available, cancel the underlying coverage and revoke your election to pay the cost of such coverage through this Flexible Benefits Plan. Coverage is deemed "lost" only if there is a complete loss of coverage (e.g., the benefit plan option is eliminated or an annual or lifetime maximum is reached) or other fundamental loss of coverage (e.g., a substantial decrease in the health care providers available under the option or a reduction in benefits for a specific type of medical condition with respect to which you or your spouse or dependent is currently receiving treatment. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

Application to Dependent Care Expense Reimbursement Plan. This rule allows you to change your election under the Dependent Care Expense Reimbursement Plan to reflect changes regarding your dependent care provider, including: (1) the termination of one provider and the hiring of another provider, and (2) the termination of a provider because a relative becomes available to care for your child at no cost. You will need to notify the Plan Administrator of any such change in coverage under the Dependent Care Expense Reimbursement Plan.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(iii) **Addition or Improvement of an Optional Benefit**. If during a Plan Year, a new plan or plan option is offered, or if coverage under an existing plan or option is significantly improved, you may enroll in the new or improved coverage and make or change your election to pay the cost of such coverage through the Flexible Benefits Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(iv) **Change Under Another Employer-Sponsored Plan**. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer) if: (i) the other plan permits its participants to make an election change that would be permitted under the prevailing IRS guidance, or (ii) the Plan Year of this Flexible Benefits Plan is different from the plan year under the other plan. For example, if your spouse drops your coverage during open enrollment under his or her employer's group medical plan and you enroll in the Employer's Group Medical Plan, you may make or change your election to pay for such coverage through the Flexible Benefits Plan.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(v) **Loss of Governmental or Educational Coverage**. If you add coverage under an Employer-sponsored group health plan (e.g., the Group Medical Plan, Group Dental Plan,) for yourself or your spouse or dependent because such individual has lost coverage under any health coverage sponsored by a governmental or educational institution (including, but not limited to, the following: a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government health plan), you may make or change your election to pay the cost of such coverage under the Flexible Benefits Plan.

NOTE: This rule does not allow changes to your election under the Medical Expense Reimbursement Plan.

(6) **Family and Medical Leave Act.** If you take a leave governed by the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke or change an election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(7) **Other**. The Plan Administrator shall have the discretion to allow a change to, or termination of, an election to the extent such change or termination is the result of any other situation informally recognized by the IRS as providing an exception to the general rule that elections are irrevocable (e.g., corrections of mistakes, failure to satisfy underwriting). If the Plan Administrator determines before or

during any Plan Year that the Flexible Benefits Plan or any Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent.

(c) **Procedure for Requesting a Change.** If a change in election is allowed under the foregoing rules, you must typically inform the Plan Administrator of your new election within thirty (30) days of the occurrence of the event allowing the change. However, if the election relates to the Dependent Care Expense Reimbursement Plan and is on account of the birth, adoption, or placement for adoption of a new child, you may have additional time to inform the Plan Administrator of the new election. Please contact the Plan Administrator for additional information.

Your election change must be on account of and consistent with the status change that has occurred. In general, that means the event must result in a change in coverage that changes the cost.

Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days, provided it applies to compensation not yet currently available. All other new elections shall be effective prospectively immediately following the date the Participant files the new election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

1.9 Who holds the funds I have set aside under the Flexible Benefits Plan?

Your salary reduction contributions are held in the Employer's general assets. There is no separate trust.

1.10 What if I terminate my employment during the Plan Year?

If your employment with the Employer terminates during the Plan Year, your active participation with this Flexible Benefits Plan ceases and your elections are terminated. You will not be able to make any more contributions under this Flexible Benefits Plan. You may, however, be entitled to continuation coverage with respect to the underlying benefit plan. See the Article describing continuation coverage for additional information.

If you are rehired after thirty (30) days following a termination of employment and again become a Participant, you will have two "periods of coverage" – that period prior to the termination of employment and that period following the re-employment. Expenses incurred prior to the termination of employment shall be subject to the election in effect upon termination. Upon re-employment, you shall have an opportunity to make a new election and expenses incurred after re-employment shall be subject to the election made upon re-employment.

If you are rehired within thirty (30) days following a termination of employment, your election in effect prior to the termination of employment will be reinstated upon re-employment.

1.11 Will I have any administrative costs under the Flexible Benefits Plan?

No. The entire cost of administering the Flexible Benefits Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

1.12 How long will the Flexible Benefits Plan remain in effect?

Although the Employer expects to maintain the Flexible Benefits Plan (including each of the Optional Benefits) indefinitely, it has the right to amend or terminate the Flexible Benefits Plan in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Flexible Benefits Plan be amended or terminated accordingly. You will be informed if any changes are made to the Flexible Benefits Plan.

1.13 Are my benefits taxable?

Since the Flexible Benefits Plan is intended to meet certain requirements of the federal tax laws, many of the benefits you receive under the Flexible Benefits Plan will not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of benefits with respect to any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax advisor.

You should realize that any medical expense you pay or are reimbursed on a pre-tax basis under this Flexible Benefits Plan cannot be claimed as a medical expense deduction on your income tax return. However, unless your medical expenses exceed ten percent (10%) of your adjusted gross income, you are not permitted to use the deduction anyway.

Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Expense Reimbursement Plan later in this summary.

If you pay the cost of health coverage through this Flexible Benefits Plan and that coverage covers someone other than your spouse or tax dependent, the value of the coverage provided to the non-tax dependent will be taxable to you. See Section 1.16 for additional information.

If the Plan Administrator determines before or during any Plan Year the Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a re-characterization within the Plan Year of benefits provided under the Plan as taxable income, with or without consent of the affected Participants.

1.14 What is the impact on my Social Security benefits?

Participating in the Flexible Benefits Plan will reduce the amount of your taxable compensation. Accordingly, your Social Security benefits, which are based upon your taxable compensation, may be affected at your retirement. However, the tax savings you obtain through participation in the Flexible Benefits Plan often will offset any reduction in your future Social Security benefits.

1.15 What contributions are made to the Flexible Benefits Plan?

(a) **Employer Contribution.** The Employer may make a fixed dollar contribution per Plan Year, or portion of a Plan Year (e.g., month, pay period), per Participant (the "Employer

Contribution"). The amount of the Employer Contribution (if any) may change from year to year as announced by the Employer prior to the Plan Year start. The Employer may designate different amounts for different groups of Eligible Employees. The Employer Contribution (if any), including any additional limitations or restrictions thereon, shall be communicated to you prior to the start of the Plan Year as part of the election materials. The portion of the Employer Contribution (if any) not used to pay for benefits [shall be paid in taxable compensation] [shall be forfeited]. No Employer Contribution (if any) shall be credited to any Employee during a period of leave of absence, whether authorized or unauthorized, unless required by the Family Medical Leave Act ("FMLA"). Employees who are not eligible for participation on the first day of the Plan Year shall have their annual Employer Contribution (if any) pro-rated by multiplying the annual available Employer Contribution (if any) by a fraction, the numerator of which is the number of months the Employee is eligible for participation for the Plan Year, the denominator which is twelve.

(b) **Salary Reduction Contributions**. To the extent the cost of an Optional Benefit exceeds the Employer Contribution (if any), you may elect in accordance with the election procedures described in Section 1.6 to receive your full compensation in cash, or to have a portion of such compensation applied by the Employer toward your share of the cost of Optional Benefits. If so elected, your compensation will be reduced, and an amount equal to the reduction will be allocated by the Employer to the Optional Benefits you have designated. Your compensation shall be reduced by pro-rata amounts of your total salary reduction election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be every payroll period. Notwithstanding the forgoing, if participation in an Optional Benefit extends to the last day of the month in which your employment terminates, if necessary, additional salary reduction contributions shall be taken from your final pay check to pay for the coverage provided during the period of time following the date on which your employment terminates.

(c) **Salary Deduction Contributions.** Sometimes the Internal Revenue Code or your Employer does not allow payment with pre-tax dollars. Payments which may be made with after-tax dollars may be paid through a salary deduction agreement. A salary deduction agreement provides for a payroll deduction to be made throughout a Plan Year out of your compensation ***after*** taxes and withholdings have been made.

1.16 What if coverage is provided to someone other than your spouse and tax dependents?

If you participate in an Optional Benefit that covers a dependent who is not your "spouse" or "tax dependent," the entire cost of coverage for Optional Benefits for which you are responsible shall be paid pre-tax through this Flexible Benefits Plan and the fair market value of the coverage for that Dependent shall be imputed as income to you as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer Contributions, if any.

For purposes of this Flexible Benefits Plan, **"spouse"** means a person of the opposite sex to whom you are legally married in accordance with applicable state law.

For purposes of this Flexible Benefits Plan, **"tax dependent"** generally includes an individual who satisfies the requirements of paragraph (a), (b) or (c) below:

(a) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(2) will not attain age 27 during the relevant calendar year.

(b) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(2) has the same principal place of abode as you for at least one-half of the relevant year;

(3) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(4) did not provide over half of his/her own support during the relevant year;

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you; and

(7) does not file a joint tax return with his or her spouse.

(c) An individual who:

(1) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(2) has received more than one-half of his/her support from you during the relevant year;

(3) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (a) above with respect to any person); and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

NOTE: The definition "tax dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent Care Expense Reimbursement Plan. Special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

1.17 How are claims determined?

NOTE: This claims determination procedure only covers issues related to the Flexible Benefits Plan (e.g., the ability to pay for benefits on a pre-tax basis and the election of Optional Benefits), claims for reimbursement under the Dependent Care Expense Reimbursement Plan and Medical Expense Reimbursement Plan, and claims for payment of premiums under Individual Premium Feature. Claims for other benefits (e.g., claims under the major medical and dental coverages or individual insurance policies) are handled through the claims determination procedures in those separate plans or policies.

(a) **Claim Submission**. Unless a separate procedure is provided with respect to an Optional Benefit, a claim for benefits must be made in writing (including online claims) and submitted to the Claims Administrator. Please refer to the sections of this summary describing each Optional Benefit for additional information.

(b) **Benefits Denials**. The Claims Administrator will decide your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator. You will receive written notice of any extension, indicating the reasons for the extension and the date by which a decision is expected to be made. If your claim is incomplete, and the Claims Administrator notifies you of that fact, the time period for deciding your claim will be suspended from the date the notice is provided through the date on which you respond or by which you are supposed to respond. You will be given at least forty-five (45) days in which to respond. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Claims Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

(1) the specific reason or reasons for the denial;

(2) reference to the specific Plan provision on which the denial is based;

(3) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

(c) **Appealing a Denial**. If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination, or else you may also have lost your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

(d) **Decision upon Appeal**. The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(1) the specific reason(s) for the denial;

(2) the specific Plan provision(s) on which the decision is based;

(3) a statement of your right to review (on request and at no charge) relevant documents and other information;

(4) if the Plan Administrator relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

(5) a statement of your right to bring suit under ERISA § 502(a).

1.18 How are insurance refunds handled?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for a component of the Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law. The refund will be allocated between the Employer and the Participants in accordance with the then prevailing United States Department of Labor (DOL) guidance. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the component of the Plan to which the refund relates; and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund of Participant premiums, a premium holiday, an increase in benefits, etc.), as determined by the Plan Administrator in it sole discretion. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

1.19 Who has authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator and any other Plan fiduciary acting in its fiduciary capacity shall have the authority and discretion to interpret and apply Plan terms.

PART II.
GROUP MEDICAL BENEFITS

2.1 What benefits are provided?

An important feature of the Flexible Benefits Plan is the opportunity it provides you to pay your share of the cost of medical coverage on a pre-tax basis. The medical coverage is provided through your Employer and is referred to herein as the "Group Medical Plan." Your share of the cost for that coverage is paid with the allocation of Employer Contributions (if any) and pre-tax dollars through salary reduction under this portion of the Flexible Benefits Plan.

The Group Medical Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers or health maintenance organizations ("HMOs"). The Group Medical Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference. If you have not been provided this information, you should contact the Plan Administrator. The group medical benefits are provided in accordance with the applicable contract or policy issued by the carrier.

The Group Medical Plan is subject to privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2.2 How do I become a Participant in this portion of the Flexible Benefits Plan?

To participate in this portion of the Flexible Benefits Plan, you must first enroll in the Group Medical Plan. You may select coverage under the Group Medical Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Medical Plan. Please refer to the contract or policy governing the Group Medical Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Medical Plan, then you may participate in this portion of the Flexible Benefits Plan if you satisfy the general eligibility requirements for the Flexible Benefits Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Flexible Benefits Plan for purposes of paying your share of the cost of Group Medical Plan coverage unless you elect not to do so.

2.3 How is the cost of group medical coverage paid?

If you participate in this portion of the Flexible Benefits Plan, the cost of coverage under the Group Medical Plan is paid by allocation of any available Employer Contribution (if any) and, to the extent the Employer Contribution (if any) is insufficient, with pre-tax dollars through salary reduction (except as provided below). Your Employer will forward the salary reduction dollars (if any) to the insurance carrier along with any Employer Contribution (if any) you have designated to be used to pay for this coverage.

NOTE: You must be a Participant in the Flexible Benefits Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Medical Plan coverage through this portion of the Flexible Benefits Plan and you have enrolled an individual who is not your spouse or "tax dependent" (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described in Section 1.16.

2.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Medical Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Medical Plan, your participation in this portion of the Flexible Benefits Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Flexible Benefits Plan, your ability to pay for coverage under the Group Medical Plan on a pre-tax basis through this portion of the Flexible Benefits Plan stops.

2.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Medical Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") applicable, the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

2.6 What if I am subject to a child support order?

The Group Medical Plan recognizes certain medical child support orders that constitute ***Qualified*** Medical Child Support Orders ("QMCSOs") under ERISA. If a child is enrolled in the Group Medical Plan pursuant to a QMCSO, you will be able to pay the cost of that coverage through this portion of the Flexible Benefits Plan, provided you are eligible to participate as described in Section 2.2.

PART III.
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

3.1 What benefits are provided?

The Plan permits you to receive reimbursement for some or all of your work related dependent care expenses under the Dependent Care Expense Reimbursement Plan ("DC Plan"). Under the DC Plan, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. You may also use the Employer Contributions (if any). Those pre-tax dollars will be used to reimburse you for your eligible expenses. You save Social Security and income taxes on the amount of your salary reduction for dependent care expenses.

NOTE: Participation in the DC Plan will impact your ability to receive the dependent care tax credit with respect to your federal income taxes. Please refer to the additional information below.

3.2 How do I become a Participant in the DC Plan?

To become a Participant in the DC Plan, you must first become a Participant in the Flexible Benefits Plan. You must also satisfy the eligibility requirements for the DC Plan. The DC Plan's eligibility requirements are the same as the eligibility requirements for the Flexible Benefits Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the DC Plan by electing benefits under the DC Plan during your initial or subsequent annual enrollment periods.

3.3 What is my dependent care account?

If you elect benefits under the DC Plan, a dependent care account ("DC Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of the Employer Contribution (if any) and, to the extent the Employer Contribution (if any) is insufficient, with pre-tax dollars through salary reduction contributions. A pro-rated portion of your election will be credited to your DC Account according to the schedule described in Section 1.15.

The amount that is available in your DC Account at any particular time will be whatever has been credited to such DC Account less any reimbursements.

The DC Account is a bookkeeping account only. The Employer pays benefits under the DC Plan from its general assets. There is no trust.

3.4 What are the maximum benefits I may receive?

The maximum amount of benefits you may receive in a tax year is $5,000 if you:

(a) are married and file a joint return;

(b) are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the DC Plan, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or

(c) are single, or a head of household for tax purposes.

NOTE: ***The maximum is a combined maximum***. If your spouse has a dependent care program available through his or her employer, the combined total under that program and this

DC Plan is the maximum described above per tax year. ***It is your responsibility to monitor your combined maximum.***

This maximum is reduced if any of the following situations exist:

(a) if you are married, reside together with your spouse, but file separate tax returns, the maximum is reduced to $2,500 (and only one parent may submit claims for reimbursement under the DC Plan); or

(b) if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

NOTE: If your spouse is a student or is incapable of caring for himself or herself, in general, your spouse will be deemed to have earned income of not less than $250 per month if you have one Qualifying Individual or $500 per month if you have two or more Qualifying Individuals.

3.5 Who is a "Qualifying Individual" for whom I can submit claims for reimbursement?

NOTE: The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual. As discussed below, special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

General Rule. Subject to the two special rules described below, you may be reimbursed for Eligible Expenses incurred with respect to any "Qualifying Individual." A Qualifying Individual is a person described in paragraph (a), (b), (c), (d) or (e) below.

(a) Your "child" who:

(1) is under age thirteen (13);

(2) has the same principal place of abode as you for at least one-half of the year;

(3) does not provide over half of his/her own support during the year; and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

(b) Your "child" who:

(1) is mentally or physically unable to care for himself or herself;

(2) has the same principal place of abode as you for at least one-half of the year;

(3) does not provide over half of his/her own support during the year;

(4) has not attained age nineteen (19) during the year (age twenty-four (24) if a full-time student);

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you; and

(7) does not file a joint tax return with his or her spouse.

(c) Your "child" who:

(1) is mentally or physically unable to care for himself or herself,

(2) has the same principal place of abode as you for at least one-half of the year,

(3) has received more than one-half of his/her support from you during the relevant year,

(4) is not any person's "qualifying child" (as that term is defined under Section 152 of the Code), and

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

(d) Your "relative" who:

(1) is mentally or physically unable to care for himself or herself,

(2) has the same principal place of abode as you for at least one-half of the year,

(3) has received more than one-half of his/her support from you during the relevant year,

(4) is not any person's "qualifying child" (as that term is defined under Section 152 of the Code), and

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

(e) Your "spouse," if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

"***Child***" generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person.

"***Relative***" generally includes parent (or a parent's ancestor), stepparent, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or an individual who (although not related to you) has the same principal place of abode as you and is a member of your household.

"***Spouse***" means an individual of the opposite sex to whom you are legally married under applicable state law.

3.6 What if two people claim a child as a Qualifying Individual?

With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are involved, there two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

(a) **Divorced or Separated Parents, or Parents Living Apart**.

> **Important Note:** Only one person is entitled to treat the child as a Qualified Individual for purposes of the DC Plan.

If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (1) the child is under age 13 or is mentally or physically unable to care for himself or herself; (2) the child receives more than 50% of his or her support from the parents (in aggregate); and (3) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year.

(b) **Other Situations**. If the special rule described above regarding divorce, etc. does not apply, other special tie-breaker rules may apply. If an individual is a Qualifying Individual (under paragraphs (a) or (b) of the definition provided above) with respect to more than one person, then:

(1) if both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resides for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan***.

(2) if one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan.***

(3) if neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then

the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan***.

Important: If you enroll for dependent care benefits, it will be assumed that you are ***the one person*** entitled to treat the child as a Qualifying Individual for purposes of reimbursement under the DC Plan.

3.7 What is an "Eligible Expense"?

(a) **General Rule—Covered**. An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. Eligible Expenses generally include:

(1) day care expenses;

(2) the cost of nursery school, preschool, or similar programs below the level of kindergarten;

(3) the cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);

(4) the cost of day camp, including specialty day camp, but ***not*** overnight camp;

(5) the cost of transportation provided by a care provider;

(6) the cost of meals incidental to and inseparable from care;

(7) employment taxes paid on behalf of a care provider;

(8) the cost of room and board provided for a care provider (e.g., a live in nanny);

(9) certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care and care is actually provided; and

(10) placement or "hold the spot" fees, if they must be paid to obtain the care and care is actually provided.

(b) **General Rule—Not Covered**. Expenses incurred that do not enable you to be gainfully employed are generally not "eligible" including, but not limited to, expenses incurred while on vacation, sick leave, or any other type of situation where you (and your spouse) are not at work or actively looking for work (i.e., gainfully employed). Your spouse, if any, is deemed to be gainfully employed if he/she is: (1) a full time student, or (2) mentally or physically incapable of self-care and resides with you for more than one-half of the calendar year.

(c) **Daily Allocation**. Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed.

Special Rule. If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time

basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

(d) **Who and Where Rules**. Expenses that would otherwise be "Eligible Expenses" cannot be reimbursed if they are paid to: (1) an individual who is your child under the age of nineteen (19) at the end of the calendar year; (2) an individual who is your (or your spouse's) tax dependent; (3) an individual who was your spouse at any time during the calendar year; or (4) a parent of a Qualifying Individual who is your child under age thirteen (13).

Expenses that would otherwise be "Eligible Expenses" for services provided outside of your home may be reimbursed only if the care is for a Qualifying Individual who is: (1) your (or your spouse's) "child" under the age of thirteen (13); or (2) is another Qualifying Individual who regularly spends at least eight (8) hours per day in your home.

3.8 How do I receive reimbursements under the DC Plan?

(a) **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, or mail. The claim form will typically set forth:

(1) the amount, date and nature of the expense;

(2) the name of the person or entity to which the expense was paid;

(3) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and

(4) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your DC Account, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

(b) **Electronic Payment Card.** The electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

(1) **You must make an election to use the card**. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.

(2) **The balance of the card is limited**. The balance of the card is limited to the balance of your DC Account.

(3) **The card will be turned off when employment or coverage terminates**. The card will be turned off when you terminate employment or coverage under the Plan.

(4) **You must certify proper use of the card**. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your DC Account will only be used for Eligible Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(5) **Expenses must be substantiated.** To ensure that expenses for which the card is used are Eligible Expenses, the following procedures must be followed:

(i) At the beginning of each Plan Year or, if later, upon beginning participation, you must pay the initial Eligible Expense to the dependent care provider and submit a paper claim to the Plan (as described above) for such expense.

(ii) Upon substantiation by the Claims Administrator of the initial Eligible Expense, the Plan will make available through the electronic payment card an amount equal to the lesser of the amount of the approved claim, or the balance of your DC Account as of that date.

(iii) The electronic payment card may then be used to pay for subsequently incurred Eligible Expenses.

(iv) The amount available through the electronic payment card may be increased only as additional dependent care expenses are incurred and substantiated via submission of a paper claim, except as provided in paragraph (v) below. In no case will the amount available through the electronic payment card exceed the contributions to your DC Account for the Plan Year to date minus the amount of expenses previously reimbursed during such Plan Year (whether such reimbursement was made in cash or by crediting the electronic payment card).

(v) Dependent care expenses may be automatically substantiated without submission of a paper claim only as provided in this paragraph (v). If (A) an electronic payment card transaction collects information that matches information for a previously approved paper claim with respect to the dependent care provider, and (B) the amount of the electronic payment card transaction is equal to or less than the previously approved paper claim, then the claim paid via the electronic payment card is substantiated without further review. In such instances, the balance of the electronic payment card may be increased with respect to the automatically substantiated claim once the expense paid through the electronic payment card has been incurred.

Example: If you use an electronic payment card to pay a day care provider on the first day of the week for the care to be provided during that week, and the claim is automatically substantiated as provided above, the balance of the electronic payment card may be increased with respect to such claim at the end of the week.

(c) **Deadline.** You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year until the last day of the second calendar month following the end of that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

3.9 What limits apply to reimbursements under the DC Plan?

You cannot be reimbursed for any expenses above your ***available*** DC Account balance. If your claim was for an amount that was more than your current DC Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the effective date of the DC Plan, for any expenses that arise before you become a Participant in the DC Plan, or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

3.10 Will I be taxed on the DC Plan benefits I receive?

You will not normally be taxed on benefits under the DC Plan. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

3.11 If I participate in the DC Plan, will I still be able to claim the dependent care tax credit on my federal income tax return?

You may choose to participate in the DC Plan and receive credit on your federal income tax return too. However, the tax credit and the DC Account cannot be used for the same expenses. In addition, the amount of the dependent care tax credit is reduced dollar for dollar by the reimbursement you receive from your DC Account.

In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the DC Account. You may want to consult your tax advisor regarding the best options under the applicable rules.

3.12 What is the dependent care tax credit?

The dependent care tax credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents.

Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents.) The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

3.13 When would it be better for me to use the tax credit?

In general, if your income tax bracket is 15% or less, it will be more advantageous for you to forego participation in the DC Plan, pay the expenses with after-tax dollars, and claim the dependent care tax credits. However, you should analyze your own situation carefully to determine which method is right for you. The actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc. Each Participant will have to determine his or her tax position individually in order to make the decisions between taxable and tax-free benefits. If you are uncertain about whether to participate in this DC Plan or take the dependent care credit, you should consult your tax advisor.

Please refer to Exhibit B for an example of how choosing between participating in the DC Plan versus taking the dependent care tax credit will impact your disposable income.

3.14 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the DC Plan, you may not make any further contributions to your DC Account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred both while you were a Participant and during the remainder of the Plan Year in which your participation ceased until the expiration of the claims run out period described above.

3.15 What if I receive benefits in error?

If a reimbursement is made by the DC Plan in excess of the amount to which you are entitled under the DC Plan, the DC Plan has the right to recover such overpayment. Repayment of an overpayment is a condition of participation in the Flexible Benefits Plan.

3.16 What if the dependent care expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your DC Account attributable to a particular Plan Year shall be forfeited following the claims run-out period described in Section 3.8(c). You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual dependent care expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

3.17 What reporting will I receive?

The amounts reimbursed under this DC Plan for each calendar year will be reported on your W-2. If the actual amount paid is not known by the deadline for providing the W-2 (e.g., because of the claims run-out period), the Employer may report a reasonable estimate of the reimbursements that will be paid under the DC Plan for the year. A reasonable estimate may be the amount of benefits you elected under the DC Plan for the year.

PART IV.
MEDICAL EXPENSE REIMBURSEMENT PLAN

4.1 What benefits are provided?

The Plan permits you to receive reimbursement for some or all of your uninsured medical and dental expenses under the Medical Expense Reimbursement Plan ("ME Plan"). Under the ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer. You may also use the Employer Contributions (if any). Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses.

The coverage provided through the ME Plan is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The ME Plan is intended to be an excepted benefit under the HIPAA portability rules. Accordingly, neither the HIPAA portability rules nor the preventative care mandate of the Patient Protection and Affordable Care Act, as amended, apply to the ME Plan.

4.2 How do I become a Participant?

To become a Participant in the ME Plan, you must first become a Participant in the Flexible Benefits Plan. You must also satisfy the eligibility requirements for the ME Plan. The ME Plan's eligibility requirements are the same as the eligibility requirements for the Flexible Benefits Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the ME Plan by electing benefits under the ME Plan during your initial or subsequent annual enrollment periods.

NOTE: Participation in this ME Plan will make you and any of your dependents covered by the ME Plan ineligible to make or receive contributions to a health savings account.

4.3 What is my medical expense account?

If you elect benefits under the ME Plan, a medical expense account ("ME Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of the Employer Contribution (if any) and, to the extent the Employer Contribution (if any) is insufficient, with pre-tax dollars through salary reduction contributions.

The full amount of your election under the ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the ME Plan received during the Plan Year.

The ME Account is a bookkeeping account only. Benefits under the ME Plan are paid from the Employer's general assets. There is no trust.

4.4 What is an "Eligible Expense"?

(a) **Generally**. An "Eligible Expense," in most situations, means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source. Eligible Expenses include expenses incurred by you and your "spouse" and "dependents."

For purposes of this ME Plan, **"spouse"** means a person of the opposite sex to whom you are legally married in accordance with applicable state law.

For purposes of this ME Plan, **"dependent"** generally includes an individual who satisfies the requirements of paragraph (1), (2) or (3) below:

(1) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(ii) will not attain age 27 during the relevant calendar year.

(2) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(ii) has the same principal place of abode as you for at least one-half of the relevant year;

(iii) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(iv) did not provide over half of his/her own support during the relevant year;

(v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(vi) is younger than you; and

(vii) does not file a joint tax return with his or her spouse.

(3) An individual who:

(i) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(ii) has received more than one-half of his/her support from you during the relevant year;

(iii) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (1) above with respect to any person); and

(iv) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

NOTE: The definition of "dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the Group Medical Plan is not necessarily a "dependent" for purposes of the ME Plan. Special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

(b) **Special rules for over-the-counter items.** Eligible Expense also ***includes*** certain over-the-counter items that constitute medical care (under Section 213(d) of the Internal Revenue Code) even though a tax deduction is not available. Over-the-counter drugs and medicines (other than insulin), require a prescription to be Eligible Expenses. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred, and (2) that is issued by an individual who is legally authorized to issue a prescription in that state.

(c) **Exceptions**. Despite the general rule stated above, Eligible Expense ***does not*** include premiums for qualified long term care coverage or premiums for any group or individual health plan.

IMPORTANT: Please review Exhibit A—Eligible Medical Care Expenses to help determine what is an Eligible Expense. You are also encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an Eligible Expense.

CAUTION: Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, ***but not all***¸ expenses that are tax deductible are also reimbursable under the ME Plan.

4.5 How do I receive my reimbursements under the ME Plan?

(a) **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, or mail. The claim form will typically set forth:

(1) the amount, date and nature of the expense;

(2) the name of the person or entity to which the expense was paid;

(3) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and

(4) such other information as the Plan Administrator may require, such as copies of bills or receipts from the providers to support your claim. With respect to claims for over-the-counter drugs and medicines (other than insulin), you must submit either: (i) a copy of the prescription, or (ii) a receipt identifying the purchaser (or patient), the date and amount of the purchase, and the Rx number.

If there are enough dollars credited to your ME Plan, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

(b) **Electronic Payment Card Claims**. The electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

(1) **You must make an election to use the card**. In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the "Cardholder Agreement"), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset ineligible claims, etc. A Cardholder Agreement will be provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.

(2) **The balance of the card is limited**. The balance of the card is limited to the balance of your ME Account.

(3) **The card will be turned off when employment or coverage terminates**. The card will be turned off when you terminate employment or coverage under the Plan.

(4) **You must certify proper use of the card**. As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your ME Account will only be used for Eligible Expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(5) **Reimbursement under the card is limited to certain places where you purchase health care related items.** Use of the card is limited to merchants who: (i) have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) have the drug store or pharmacies merchant category code and with respect to whom 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (a "90% pharmacy"); or (iii) participate in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.

(6) **You swipe the card at the health care provider like you do any other credit or debit card**. When you incur an Eligible Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your ME Account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an Eligible Expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.

(7) **You must obtain and retain a receipt/third party statement each time you swipe the card**. You must obtain a third party statement from the health

care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:

i) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;

ii) The date the expense was incurred; and

iii) The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for one year following the close of the Plan Year in which the expense was incurred. Even though payment may be made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 45 days (or such longer period provided in the letter from the Claims Administrator) of the request.

(8) **There are situations where the third party statement will not be required to be provided to the Claims Administrator**. There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:

i) **Co-Pay Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under the Employer's group medical plan for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.

ii) **Previously Approved Claim Match**. No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).

iii) **Provider Match Program**. No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is

accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that verifies the nature and amount of the expense and that the expense is an eligible expense.

iv) **Inventory Information Approval System**: No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

> **Note**: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

(9) **Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin.** Notwithstanding the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:

i. At any 90% pharmacy if the expense is substantiated after the purchase in accordance with paragraph (7) above.

ii. At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (A) the cardholder presents the prescription to the pharmacist; (B) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (C) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (D) the pharmacy's records are accessible by the employer or its agent; (E) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (F) the expense is substantiated in accordance with the standard rules described above in paragraphs (7) and (8).

iii. At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with the standard rules described above in paragraphs (7) and (8).

> **Note:** If the over-the-counter medicine cannot be purchased with the electronic payment card, it may still be reimbursed using the manual reimbursement procedures described in paragraph (a) above.

(10) **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. If you do not repay the Plan by the deadline set by the Claims Administrator, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable

law). If the Employer is unable to withhold the amount from your pay, an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, the remaining unpaid amount may be treated as an indebtedness to the Employer.

(11) **You can use either the payment card or the paper claims approach**. You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the paper claims approach discussed above. Claims for which the electronic payment card has been used cannot be submitted as paper claims.

(12) **Your use of the payment card is not a claim**. The use of an electronic payment card does not constitute a "claim" under the claims procedures.

(c) **Deadline.** You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year until the last day of the second calendar month following the end of that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

4.6 What limits apply to reimbursements under the ME Plan?

You cannot be reimbursed for any expenses above the amount of your ME Account balance. You also cannot be reimbursed for any expenses that were incurred before the effective date of the ME Plan, for any expenses incurred before you become a Participant in the ME Plan, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

Special Rule: A special rule applies to expenses for **orthodontia care**. Such expenses may be reimbursed before the orthodontia care has been provided if you have actually paid the healthcare provider in advance in order to receive the services (e.g., an upfront payment required to receive services).

4.7 What are the maximum reimbursements I may receive?

The maximum amount of medical expense reimbursements is the maximum as allowed by current regulations per Plan Year. If you enter the plan mid-year, this maximum amount will be prorated for the number of pay periods remaining in the Plan Year.

4.8 Which plan pays first if I participate in the Employer's health reimbursement arrangement?

If you participate in a health reimbursement arrangement (the "HRA") sponsored by the Employer and you or your spouse or dependent incurs an Eligible Expense that is also eligible for reimbursement under the HRA, then the Eligible Expense must be reimbursed from this Health FSA first.

Once your Health FSA balance has been exhausted, then an Eligible Expense, or any portion of an Eligible Expense that has not been reimbursed by this Health FSA, may be reimbursed by the HRA.

4.9 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the ME Plan, your benefits under the ME Plan stop. You may not make any further contributions to your ME Account, and you may not submit claims for reimbursement of expenses incurred after you terminated employment or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you terminated employment or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described above.

4.10 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the ME Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These continuation rights are described later in this summary.

4.11 Can I carryover my ME Account to the next Plan Year?

Yes. The ME Plan will provide a limited carryover of ME Account balances from Plan Year to Plan Year in accordance with the following conditions and restrictions:

(a) You may carry over the lesser of: (i) $500 or (ii) the balance of your ME Account remaining at the end of the Plan Year. The actual balance of your ME Account that may be carried over will be determined upon expiration of claims run-out period described above. Note, the balance of your ME Account at any point in time shall be equal to the amount credited to the ME Account for the Plan Year minus claims paid to date with respect to that Plan Year.

(b) Although the balance of your ME Account that is available for the carryover is not determined until the close of the claims run-out period, your ME Account balance as of midnight on the last day of the Plan Year, up to the amount specified in paragraph (a) above, will be available to reimburse Eligible Expenses incurred on and after the first day of the new Plan Year. The Claims Administrator will administer claims submitted during the claims run out period (including allocating claims between your carryover balance and your election for the new Plan Year (if any)) in a manner consistent with applicable law (including regulatory guidance).

(c) In general, carryovers occur automatically. However, you may elect, in accordance with procedures adopted by the Plan Administrator, to waive the carryover. You must make such an election no later the last day of the Plan Year from which the carryover is to be made.

(d) Unless otherwise required under applicable law (including regulatory guidance), you will receive a carryover only if you are eligible to make elections under the ME Plan (or Limited Scope ME Plan) as of the first day of the Plan Year to which the carryover will be made (regardless of whether you actually elect to participate in the Plan for that Plan Year).

(e) A carryover does not count against the maximum reimbursement you may receive under the ME Plan for a Plan Year as described above.

Any amounts remaining in your ME Account attributable to a particular Plan Year after the carryover shall be forfeited. You will not be entitled to receive any direct or indirect payment of any amount in your ME Account in excess of the amount that may be carried over to the next Plan Year. ***If you do not use it and it cannot be carried over, you lose it.***

4.12 What if I receive benefits in error?

If a payment for benefits is made by the ME Plan in excess of the benefit to which you are entitled under the ME Plan, the ME Plan has the right to recover such overpayment from the payee. Repayment of an overpayment is a condition of participation in the Flexible Benefits Plan.

4.13 What if I am subject to a child support order?

Notwithstanding any provision in the ME Plan to the contrary, the ME Plan shall recognize ***Qualified*** Medical Child Support Orders ("QMCSOs"). To be a QMCSO certain procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

PART V.
GROUP DENTAL BENEFITS

5.1 What benefits are provided?

An important feature of the Flexible Benefits Plan is the opportunity it provides to pay your share of the cost of dental coverage on a pre-tax basis. The dental coverage is provided through your Employer and is referred to herein as the "Group Dental Plan." Your share of the cost for that coverage is paid with the allocation of Employer Contributions (if any) and pre-tax dollars through salary reduction under this portion of the Flexible Benefits Plan.

The Group Dental Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers or health maintenance organizations ("DMOs"). The Group Dental Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or DMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference. If you have not been provided this information, you should contact the Plan Administrator. The group dental benefits are provided in accordance with the applicable contract or policy issued by the carrier.

The Group Dental Plan is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

5.2 How do I become a Participant?

To participate in this portion of the Flexible Benefits Plan, you must first enroll in the Group Dental Plan. You may select coverage under the Group Dental Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Dental Plan. Please refer to the contract or policy governing the Group Dental Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Dental Plan, then you may participate in this portion of the Flexible Benefits Plan if you satisfy the general eligibility requirements for the Flexible Benefits Plan described in Section 1.4.

5.3 How is the cost of group dental coverage paid?

If you participate in this portion of the Flexible Benefits Plan the cost of coverage under the Group Dental Plan is paid by allocation of any available Employer Contribution (if any) and, to the extent the Employer Contribution (if any) is insufficient, with pre-tax dollars through salary reduction (except as provided below). Your Employer will forward the salary reduction dollars (if any) to the insurance carrier along with any Employer Contribution (if any) you have designated to be used to pay for this coverage.

NOTE: You must be a Participant in the Flexible Benefits Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Dental Plan coverage through this portion of the Flexible Benefits Plan and you have enrolled an individual who is not your spouse or "tax dependent" (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described in Section 1.16.

5.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Dental Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Dental Plan, your participation in this portion of the Flexible Benefits Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Flexible Benefits Plan, your ability to pay for coverage under the Group Dental Plan on a pre-tax basis through this portion of the Flexible Benefits Plan stops.

5.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Dental Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") applicable the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

5.6 What if I am subject to a child support order?

The Group Dental Plan recognizes certain medical child support orders that constitute ***Qualified*** Medical Child Support Orders ("QMCSOs") under ERISA. If a child is enrolled in the Group Dental Plan pursuant to a QMCSO, you will be able to pay the cost of that coverage through this portion of the Flexible Benefits Plan, provided you are eligible to participate as described in Section 2.2.

PART VI.
GROUP TERM LIFE AND AD&D BENEFITS

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PART VII.
INSURANCE PREMIUM FEATURE

7.1 What benefits are provided?

The Plan permits you to pay or receive reimbursement for the cost of certain individual insurance policies under the Individual Premium Feature (the "IP Feature"). Under the IP Feature, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. You may also use Employer Contributions (if any). Those pre-tax dollars will be used to pay or reimburse you for your eligible expenses. You save Social Security and income taxes on the amount of your salary reduction for individual insurance policy expenses.

7.2 How do I become a Participant in the IP Feature?

To become a Participant in the IP Feature, you must first become a Participant in the Flexible Benefits Plan. You must also satisfy the eligibility requirements for the IP Feature. The IP Feature's eligibility requirements are the same as the eligibility requirements for the Flexible Benefits Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the IP Feature by electing benefits under the IP Feature during your initial or subsequent annual enrollment periods.

NOTE: Keep in mind the general rule regarding irrevocable elections. Unless a recognized exception to the irrevocable election rule applies, the election is irrevocable for the Plan Year; even if the underlying individual insurance policy changes or is no longer in effect.

7.3 What is my individual premium account?

If you elect benefits under the IP Feature, an individual premium account ("IP Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of the Employer Contribution (if any) and, to the extent the Employer Contribution (if any) is insufficient, with pre-tax dollars through salary reduction contributions. A pro-rated portion of your election will be credited to your IP Account according to the schedule described in Section 1.15.

The amount that is available in your IP Account at any particular time will be whatever has been credited to such IP Account less any reimbursements.

The IP Account is a bookkeeping account only. The Employer pays benefits from its general assets. There is no trust.

7.4 What coverage can be paid pre-tax?

CAUTION: Not all individual policies are eligible for pre-tax payment.

In order to be eligible for payment or reimbursement under the IP Feature, an individual insurance policy must meet all of the following requirements:

(a) The individual policy must be obtained by the Participant.

(b) The coverage must not violate the terms of the Flexible Benefits Plan and/or the requirements under the Internal Revenue Code. This includes, but is not limited to, excluding coverage that results in deferred compensation from one year to another year.

A copy of the policy must be provided to the Employer, and is incorporated by reference into the Flexible Benefits Plan.

If the other requirements described above are satisfied, Eligible Expenses include premiums for coverage provided to both you and your "dependents." For purposes of this IP Feature, **"dependent"** generally includes an individual who satisfies the requirements of paragraph (a), (b), (c), or (d) below:

(a) A person of the opposite sex to whom you are legally married in accordance with applicable state law.

(b) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(2) and will not attain age 27 during the relevant calendar year.

(c) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(2) has the same principal place of abode as you for at least one-half of the relevant year;

(3) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(4) did not provide over half of his/her own support during the relevant year;

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you; and

(7) does not file a joint tax return with his or her spouse.

(d) An individual who:

(1) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(2) has received more than one-half of his/her support from you during the relevant year;

(3) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (1) above with respect to any person); and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

> **NOTE**: This definition of "dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the individual policy is not necessarily a "dependent" for purposes of the IP Feature. Special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

For purposes of this IP Feature, **"dependent"** generally includes any individual who is eligible for coverage as a dependent under the individual policy. However, if you pay the cost of an individual policy through this portion of the Flexible Benefits Plan and the policy covers individual who is not your "spouse" or "tax dependent" (as those terms are defined in Section 1.16), then the fair market value of that individual's coverage will be handled as described in Section 1.16.

7.5 How do I receive my benefits under the IP Feature?

(a) **Periodic Reimbursements.** When you incur an insurance premium that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator's website. The claim form will typically set forth: (i) the amount, date and nature of the expense, (ii) the name of the person or entity to which the expense was paid, (iii) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source, and (iv) such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim. If there are enough dollars credited to your IP Account, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

(b) **Deadline.** You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year until the last day of the second calendar month following the end of that Plan Year. This period following the end of the Plan Year during which claims for reimbursement may be filed is referred to as the "claims run-out period."

7.6 What limits apply to payments or reimbursements under the IP Feature?

You cannot be reimbursed for any expenses above your ***available*** IP Account balance. If your claim was for an amount that was more than your current IP Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the effective date of the IP Feature, for any expenses that arise before you become a Participant in the IP Feature, or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the coverage which gives rise to the expense is provided, not when you are billed or when you pay the expense.

7.7 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the IP Feature, you may not make any further contributions to your IP Account. However, you may continue to

submit claims for reimbursement of Eligible Expenses incurred both while you were a Participant and during the remainder of the Plan Year in which your participation ceased until the expiration of the claims run out period described above.

NOTE: This does not necessarily mean that the insurance coverage stops. That is determined based upon the terms and conditions of the particular insurance policy.

7.8 What if the Eligible Expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your IP Account attributable to a particular Plan Year shall be forfeited following the claims run-out period described above. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

7.9 What if I am subject to a child support order?

CAUTION: This provision applies only to the extent the individual policies paid or reimbursed through the IP Feature are considered a group health plan for purposes of applicable child support laws.

Notwithstanding any provision in the Flexible Benefits Plan to the contrary, the Flexible Benefits Plan shall recognize ***Qualified*** Medical Child Support Orders ("QMCSOs") with respect to the IP Feature. To be a QMCSO certain procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

PART VIII.
HSA CONTRIBUTION FEATURE

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PART IX.
LIMITED SCOPE MEDICAL EXPENSE BENEFITS

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PART X.
CASH PAYMENT

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PART XI.
CONTINUATION COVERAGE

11.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. The Group Medical Plan, Group Dental Plan, Medical Expense Reimbursement Plan, shall be operated consistent with COBRA. And pursuant to DOBRA policies and procedures contained in a separate document and is incorporated by reference into this Summary Plan Description. This document is available to you upon request, at no charge.

11.2 What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation right under COBRA (if any). The Group Medical Plan, Group Dental Plan, Medical Expense Reimbursement Plan, shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document and is incorporated by reference into this Summary Plan Description. This document is available to you upon request, at no charge.

11.3 What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance (including medical and dental insurance) upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Plan Administrator.

PART XII.
FAMILY AND MEDICAL LEAVE ACT OF 1993

12.1 Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Flexible Benefit Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities.

NOTE: You should contact your Employer regarding any FMLA questions. The Claims Administrator does not have authority to make these decisions.

PART XIII.
STATEMENT OF ERISA RIGHTS

NOTE: The Flexible Benefits Plan and Dependent Care Expense Reimbursement Plan, HSA are not subject to ERISA and this Statement of ERISA Rights does not apply to them.

As a Participant in certain Optional Benefits of this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

Receive Information About Your Plans and Benefits.

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

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

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

COBRA and HIPAA Rights.

(a) Continue health coverage for yourself, your spouse or your dependents if there is a loss in 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, and

(b) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants

and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you 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 HIPAA, 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.

Plan Administrator: Your Employer is the Plan Administrator. MOR Strategy Group, LLC is the Claims Administrator and acts as your Employer's designee. All notices and other communication should be directed to: MOR Strategy Group, LLC, 958 Mezzanine Drive, Suite B, Lafayette, IN 47905; Phone: 765-446-0700.

PART XIV.
ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	LTX, Inc. Flexible Benefits Plan
Plan Type:	Section 125 Cafeteria Plan

Employer, Plan Administrator, and Agent for Service of Legal Process:

Name:	LTX, Inc.
Address:	1515 Industrial Drive NW
City, State Zip:	Rochester, MN 55901
Phone/Fax Number:	800-328-7224/ 507-287-1206
EIN:	41-0908878
Contact Person:	Bill Frank

PLAN NAME	PLAN TYPE	PLAN NUMBER
LTX, Inc. Flexible Benefits Plan	Cafeteria Plan	N/A
LTX, Inc. Group Medical Plan	Health and Accident	
LTX, Inc. Dependent Care Expense Reimbursement Plan	Dependent Care Expense Reimbursement	N/A
LTX, Inc. Medical Expense Reimbursement Plan	Health and Accident	
LTX, Inc. Group Dental Plan	Health and Accident	

Claims Administrator:

Benefit/plan	Claims Administrator Address/Phone #
• LTX, Inc. Flexible Benefits Plan • LTX, Inc. Medical Expense Reimbursement Plan • LTX, Inc. Dependent Care Expense Reimbursement Plan • LTX, Inc. Individual Premium Expense Plan • LTX, Inc. Limited Scope Medical Expense Reimbursement Plan	MOR Strategy Group, LLC 958 Mezzanine Drive, Suite B Lafayette, IN 47905 Phone: 765-446-0700

This Plan does not have a trust; therefore, there are no trustees.

EXHIBIT A
Eligible Medical Care Expenses

ME Plan. Medical and dental expenses that qualify as expenses for medical care under Internal Revenue Service rules generally qualify as Eligible Expenses for reimbursement under the ME Plan. Those may take the form of co-pays, deductibles, and medical expenses not covered by other insurance. Often expenses that qualify for deductions under IRS rules are Eligible Expenses, but in some instances expenses that are deductible will not be reimbursable and expenses that are not deductible will be reimbursable. Some specific examples are identified below. The following is not an exhaustive list and there are other expenses that are eligible if they satisfy the IRS rules.

Dental & Orthodontic Care	
Allowable expenses: • Dental treatment • Artificial teeth/dentures • Braces, orthodontic devices	*Expenses specifically disallowed by the IRS or courts*: • Teeth whitening • Toothbrushes and toothpaste, even if special type is recommended by dentist
Therapy Treatments	
Allowable expenses: • X-ray treatments • Treatment for alcoholism or drug dependency • Legal sterilization • Acupuncture • Vaccinations • Hair transplant • Electrolysis • Physical therapy (as a medical treatment) • Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical condition such as rheumatoid arthritis • Speech therapy • Smoking cessation programs and prescribed drugs to alleviate nicotine withdrawal	*Expenses specifically disallowed by the IRS or courts*: • Physical treatments unrelated to a specific health problem (e.g., massage for general well being) • Any illegal treatment • Cosmetic surgery • Treatment for baldness (unless it is for a specific medical condition and not for cosmetic purposes)
Fees/Services	
Allowable expenses: • Physician's fees and hospital services • Nursing services for care of a specific medical ailment • Cost of a nurse's room and board if paid by the taxpayer where nurse's services qualify • Social Security tax paid with respect to wages of a nurse where nurse's services qualify • Services of chiropractors • Christian Science practitioner fees • Diagnostic tests	*Expenses specifically disallowed by the IRS or courts*: • Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature • Nursemaids or practical nurses who render general care for healthy infants • Fees for exercise, athletic, or health club membership when there is no specific health reason for needing membership • Marriage counseling provided by clergyman
Hearing Expenses	
Allowable expenses: • Hearing aids and hearing aid batteries • Hearing aid repair • Special telephone equipment	

Medicine and Drugs

Allowable expenses:

- Medicine and drugs that require a prescription
- Insulin
- Prescribed over the counter medicine and drugs when used to alleviate or treat personal injuries or sickness (including antacids, antihistamines, aspirin/pain relievers, cold medicines, acne medicine, etc.)

Expenses specifically disallowed by the IRS or courts:

- Medicine and drugs for personal, general health, or cosmetic purposes
- Dietary supplements if for general health

Medical Equipment

Allowable expenses:

- Blood sugar test kits
- Wheelchair or autoette (cost of operating/maintaining)
- Crutches (purchased or rented)
- Special mattress & plywood boards prescribed to alleviate arthritis
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial limbs
- Support hose (if medical necessary)
- Wigs (where necessary to mental health of individual who loses hair because of disease)
- Excess cost of orthopedic shoes over cost of ordinary shoes
- Breast pumps for nursing mothers

Expenses specifically disallowed by the IRS or courts:

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy
- Mechanical exercise device not specifically prescribed by physician

Physicals

Allowable expenses:

- Physicals and other well visits
- Immunizations

Expenses specifically disallowed by the IRS or courts:

- Physicals for employment purposes

Vision Care

Allowable expenses:

- Optometrist's or ophthalmologist's fees
- Eyeglasses and prescription sunglasses
- Insurance for replacement of lost or damaged contact lenses
- Contact lens and contact lens solutions
- Laser eye surgery

Assistance for the Handicapped

Allowable expenses:

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

Psychiatric Care	
Allowable expenses: • Services of psychotherapists, psychiatrists and psychologists	*Expenses specifically disallowed by the IRS or courts*: • Psychoanalysis undertaken to satisfy curriculum requirements of a student
Miscellaneous Charges	
Allowable expenses: • X-rays • Expenses for services connected with donating an organ • Excess cost of medically prescribed diet • The cost of a medically prescribed weight loss program • Breast reconstructive surgery following mastectomy as part of treatment for cancer • Contraceptives • Fertility treatments • Medical records charges • Cost of transportation primarily for and essential to medical care (e.g., the expense of traveling to and from a medical service provider) • Bandages • Lactation supplies for nursing mothers	*Expenses specifically disallowed by the IRS or courts:* • Expenses of divorce when doctor or psychiatrist recommends divorce • Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes) • Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or taxpayer cannot show cost in excess of cost of a normal diet • Maternity clothes • Diaper service • Distilled water purchased to avoid drinking fluoridated county water supply • Installation of power steering in automobile • Pajamas purchased to wear in hospital • Mobile telephone used for personal calls as well as calls to physician • Union dues for sick benefits for members • Contributions to state disability funds • Auto insurance providing medical coverage for all persons injured in or by the taxpayer's automobile, where amounts allocable to taxpayer and dependent is not stated separately • Long-term care services • Funeral expenses
Insurance	
Allowable expenses: • None	*Expenses specifically disallowed by the IRS or courts:* • Health insurance premiums (including individual and non-employer sponsored coverage) • Long term care insurance premiums

EXHIBIT B
DC PLAN v. Claiming Dependent Care Tax Credit

EXAMPLE – MARRIED EMPLOYEE WITH TWO CHILDREN EARNING $48,000	DC PLAN	CLAIMING DEPENDENT CARE TAX CREDIT
1. W-2 Gross Wages (both spouses combined)	$48,000.00	$48,000.00
2. DC PLAN Salary Reductions	-$5,000.00	$0.00
3. W-2 Gross Wages	$43,000.00	$48,000.00
4. Standard Deduction	-$11,400.00	-$11,400.00
5. Exemptions (4 individuals x $3,650)	-$14,600.00	-$15,600.00
6. Taxable Income (line 3 minus lines 4 and 5)	$17,000.00	$22,000.00
Calculation of Disposable Income		
7. W-2 Gross Wages	$43,000.00	$48,000.00
8. Out-of-Pocket Dependent Care Expenses Not Reimbursed by DC PLAN	$0.00	-$5,000.00
9. FICA Tax (calculated separately on each spouse's share of the wages)	-$3,290.00	-$3,672.00
10. Federal Income Tax (line 6 @ tax schedule)	-$1,713.00	-$2,463.00
11. Non-Refundable Dependent Care Tax Credit	$0.00	$1,000.00
12. Non-Refundable Child Tax Credit	$1,713.00	$1,463.00
13. Refundable Earned Income Tax Credit	$500.00	$0.00
14. Refundable Additional Child Tax Credit	$287.00	$537.00
15. Refundable Making Work Pay Credit	$800.00	$800.00
15. **Disposable Income** (line 7 minus lines 8-10 plus lines 11-14)	**$41,297.00**	**$40,665.00**