

LAWRENCE TRANSPORTATION COMPANY, INC.

FLEXIBLE BENEFITS PLAN

Group No.: 10717

Plan Document and Summary Plan Description

Effective: January 1, 2018



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PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT

Purpose of the Plan

Lawrence Transportation Company, Inc. (the "Plan Sponsor") has adopted the Lawrence Transportation Company, Inc. Flexible Benefits Plan (the "Plan") as set forth herein and as amended from time to time for the exclusive benefit of eligible Employees. The purpose of this Plan is to allow eligible Employees to pay eligible Qualified Medical Flexible Spending Expenses, Qualified Dependent Care Flexible Spending Expenses, and their share of premiums under the Benefit Plan ("Benefit Costs") using pre-tax dollars.

The intention of the Plan Sponsor is that the Plan qualifies as a "cafeteria Plan" within the meaning of Code § 125 and the Plan shall be construed in a manner consistent with that Section. The tax implications of this Plan, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the Plan Sponsor does not represent or warrant to any Participant that any particular tax consequence will result from participation in this Plan. By participating in this Plan, each Participant understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Plan Sponsor.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under Code §§ 105 and 125.

Effective Date

This Plan document and Summary Plan Description is effective as of January 1, 2018, and each subsequent amendment is effective as of the date set forth therein (the "effective date").

Adoption of the Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description as the written description of the Plan. This Summary Plan Description amends and replaces any prior statement of the benefits contained in the Plan or any predecessor to the Plan.

GENERAL PLAN INFORMATION

Name of Plan: Lawrence Transportation Company, Inc. Flexible Benefits Plan

Plan Sponsor: (Named Fiduciary) Lawrence Transportation Company, Inc.
1515 Industrial Drive NW
Rochester, MN 55901
(507) 282-6715

Plan Administrator: Lawrence Transportation Company, Inc.
1515 Industrial Drive NW
Rochester, MN 55901
(507) 282-6715

Plan Sponsor ID No. (EIN): 41-1884879

Plan Year: January 1 - December 31

Plan Number: 510

Plan Type: Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan under Code §§ 106, 125, and 129

Third Party Administrator: Meritain Health, Inc.
P.O. Box 30111
Lansing, MI 48909
(800) 566-9305

Agent for Service of Process: Lawrence Transportation Company, Inc.
Plan Administrator
1515 Industrial Drive NW
Rochester, MN 55901
(507) 282-6715

DEFINITIONS

In this section, you will find the definitions for the capitalized words found throughout this Summary Plan Description. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Alternate Recipient means any child of a Participant who is recognized under a Medical Child Support Order as having a right to benefits under this Plan as a Participant's Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as a Dependent, but for purposes of reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

Annual Enrollment Period means the period of time designated by the Plan Sponsor or Plan Administrator each year when eligible Employees may enroll for participation and make elections under the Plan for the following Plan Year.

Benefit Cost means the cost of premiums for coverage for a Participant, his Spouse and Dependent children under the Benefit Plan in which a Participant is required to pay, as a condition of coverage.

Benefit Plan means the medical plan established and maintained by the Plan Sponsor, or any successor thereto.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Cosmetic Surgery means any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Debit Card means a banking card enhanced with POS (point-of-sale) features, issued by the Plan Sponsor to a Participant that can be used to pay for Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses electronically.

Dependent has the same meaning, if any, as set forth in the underlying Benefit Plan. For purposes of a qualifying medical spending account, Dependent includes and is limited to (i) a Participant's Spouse (as determined under federal law), (ii) any person who qualifies as the Participant's Dependent (as defined in Code Section 152, but disregarding subsections (b)(1), (b)(2), and (d)(1)(B) of section 152) or (iii) the Participant's child (as defined in Code Section 152(f)(1), but only if the child is under age 26 on the first day of the applicable calendar year). For purposes of any other Benefit Plan offered under the Plan, if the underlying Benefit Plan provides health coverage for dependents but does not include a definition of Dependent, Dependent means (i) a Participant's Spouse, (ii) a Participant's child (as defined in Code Section 152(f)(1)) who is under age 26 or (iii) a Participant's unmarried child (as defined in Code Section 152(f)(1)) who is age 26 or older and who, for the applicable calendar year depends on the Participant for more than half of his or her support, if the child is physically or mentally incapable of self-support, but only if the physical or mental disability commenced before the child reached age 26.

Dependent Care Center means any facility which:

- (1) Complies with all applicable laws and regulations of the state and unit of local government in which it is located;
- (2) Provides care for more than six individuals (other than individuals who reside at the center); and
- (3) Receives a fee, payment or grant for providing services for any of such individuals (regardless of whether such facility is operated for profit).

Earned Income means the sum of the amounts set forth in the first section below, but shall exclude the amounts set forth in the second section below:

(1) Earned Income includes the following:

- (a) Wages, salaries, tips and other Employee compensation, but only if such amounts are includable as gross income for the taxable year; and
- (b) The amount of an Employee's net earnings from self-employment for the taxable year (within the meaning of Code § 1402(a)). Such net earnings shall be determined with regard to the deductions allowed to the Employee under Code § 164(f).

(2) Earned Income excludes the following:

- (a) Amounts received under this Plan or any other Dependent care assistance Plan under Code § 129;
- (b) Amounts received as a pension or annuity (within the meaning of Code § 32(c)(2));
- (c) Amounts to which Code § 871(a) applies;
- (d) Amounts attributed to an individual pursuant to community property laws (within the meaning of Code § 32(c)(2));
- (e) Amounts attributable to wages or salary which were reduced pursuant to a written Salary Contribution Agreement; and
- (f) Amounts received for services provided by the Participant while the Participant is incarcerated in a penal institution.

Employee means a person who is an Employee of the Employer, regularly scheduled to work for the Employer in an Employer-Employee relationship. The term Employee does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation. Please refer to the section, "Eligibility for Participation," for information concerning which Employees are eligible to participate in the Plan.

Employer means Lawrence Transportation Company, Inc., or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family Medical Leave Act of 1993, as amended.

Health Care Expense means an expense Incurred for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. A Health Care Expense is not one that is merely beneficial to the general health of an individual.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Incurred means the date the service is rendered, the date the supply is obtained or, with respect to Orthodontia services the date the Employee has paid for such services. With respect to a course of treatment or procedure that includes several steps or phases of treatment (other than with respect to Orthodontia services) expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Notwithstanding the preceding, otherwise eligible expenses for orthodontia services that are paid before the services are provided will be treated as Incurred at the time that the payment is actually made but only to the extent that the Employee is required to make the advance payment to receive the services.

Medical Child Support Order or MCSO means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- (1) Provides for child support with respect to a Participant's child or directs a Participant to provide coverage under a health Benefit Plan pursuant to a state domestic relations law (including community property law); or
- (2) Enforces a law relating to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health Plan.

National Medical Support Notice or NMSN means a notice that contains the following information:

- (1) The name of an issuing state agency;
- (2) The name and mailing address (if any) of an Employee who is a Participant in the Plan;
- (3) The name and mailing address of one or more Alternate Recipients or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipient(s); and
- (4) The identity of an underlying child support order.

Participant means an eligible Employee who is participating in the Plan.

Plan means the Lawrence Transportation Company, Inc. Flexible Benefits Plan.

Plan Administrator means Lawrence Transportation Company, Inc.

Plan Sponsor means Lawrence Transportation Company, Inc.

Plan Year means the period from January 1 - December 31 each year.

Premium Only Plan means the vehicle through which a Participant may elect to pay his share of Benefit Costs by reducing his salary and using pre-tax dollars.

Privacy Standards means the final rule implementing HIPAA's Standards for Privacy of Individually Identifiable Health Information, as amended.

Qualified Beneficiary means:

- (1) An individual who, on the day before a Qualifying Event, is a Spouse or Dependent child receiving health benefits under the Plan; or
- (2) In the case of a Qualifying Event resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such Qualifying Event, is a Participant.

A newborn child of, an adopted child of, or a child placed for adoption with, a qualified beneficiary (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the qualified beneficiary; however, such child shall not become a qualified beneficiary.

A newborn child or child placed for adoption with a qualified beneficiary (as defined in the second bullet above) shall become a qualified beneficiary in his own right and shall be entitled to benefits as a qualified beneficiary.

A qualified beneficiary must notify the Plan Administrator within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

Qualified Dependent Care Flexible Spending Account means the account established by the Plan Administrator on behalf of a Participant who elects to have amounts withheld from his salary in order to pay Qualified Dependent Care Flexible Spending Expenses.

Qualified Dependent Care Flexible Spending Expenses means employment-related Dependent care expenses which are eligible for reimbursement under the Plan as determined under Code §§ 129(e)(1) and 21(b). Such expenses include amounts paid for household services and for the care of Qualifying Individuals enabling the Participant to be gainfully employed.

Qualified Medical Child Support Order or QMCSO means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits for which a Participant or eligible Dependent is entitled under this Plan. In order for such order to be a Qualified Medical Child Support Order, it must clearly specify the following:

- (1) The name and last known mailing address (if any) of a Participant and the name and mailing address of each such Alternate Recipient covered by the order;
- (2) A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
- (3) The period of coverage to which the order pertains; and
- (4) The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a Qualified Medical Child Support Order if it:

- (1) Contains the information set forth above in the definition of National Medical Support Notice;
- (2) Identifies either the specific type of coverage or all available group health coverage. If the Employer receives a National Medical Support Notice that does not designate either specific types of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
- (3) Informs the Plan Administrator that, if a group health Plan has multiple options and a Participant is not enrolled, the issuing agency will make a selection after the National Medical Support Notice is qualified; and
- (4) Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to a Participant and eligible dependents, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act § 1908 (as added by the Omnibus Budget Reconciliation Act of 1993 § 13822).

Qualified Medical Flexible Spending Account means the account established by the Plan Administrator on behalf of the Participant through which the Participant may elect to reduce his salary in order to pay Qualified Medical Flexible Spending Expenses.

Qualified Medical Flexible Spending Expenses means a Health Care Expense which is excludable as income according to Code § 105(b). Qualified Medical Flexible Spending Expenses are not otherwise reimbursable under the Benefit Plan or other Plan or by any other entity and may not be claimed as a tax deduction by the Participant. Qualified Medical Flexible Spending Expenses do not include the cost of insurance premiums.

Qualifying Individual means:

- (1) A Dependent of a Participant who is under the age of 13;
- (2) A Dependent of a Participant, regardless of age, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than one-half of the tax year; or
- (3) The Spouse of a Participant who is physically or mentally incapable of caring for himself who has the same principal place of abode as the Participant for more than one-half of the tax year.

Qualifying Event means any of the following with respect to participation in the Plan:

- (1) The termination of coverage due to the death of a Participant;
- (2) The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a Participant;
- (3) The divorce or legal separation of a Participant from his Spouse;
- (4) A Participant's entitlement to Medicare coverage; or
- (5) A Dependent child ceasing to be a Dependent child.

Salary Contribution Agreement means a written agreement by a Participant to reduce his salary or wage in order to fund a Qualified Medical Flexible Spending Account, a Qualified Dependent Care Flexible Spending Account, or to pay Benefit Costs.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Spouse has the same meaning, if any, as set forth in the underlying Benefit Plan.

Student means an individual who, during each of 5 calendar months during a taxable year, is a full-time Student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of Students in attendance at the place where its educational activities are regularly carried on.

Summary Health Information means individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip Code.

Summary Plan Description means this Plan Document and Summary Plan Description. This Summary Plan Description represents both the Plan Document and the Summary Plan Description that is required by ERISA.

Third Party Administrator means Meritain Health, Inc., P.O. Box 30111, Lansing, MI 48909, (800) 566-9305.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

USERRA means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

Waiting Period means an interval of time during which the eligible Employee is in the continuous, active employment of his Employer before he becomes eligible to participate in the Plan.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility

You are eligible to enroll for coverage under this Plan if you are an active, full-time Employee regularly scheduled to work at least 30 hours per week and you have completed a Waiting Period of 60 days from the date that you completed at least one hour of service with the Employer. Participation in the Plan will begin as of the first day of the month following completion of the Waiting Period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

However, you may elect to make contributions to the Premium Only Plan component only if you participate in the Benefit Plan.

You must complete a proper Salary Contribution Agreement within 30 days from your original eligibility date in order to participate in this Plan for the Plan Year.

If you are enrolling during an Annual Enrollment Period, your entry date will be January 1st following the Annual Enrollment Period, provided that you have completed a Salary Contribution Agreement.

By completing the Salary Contribution Agreement you will be enrolling in this Plan. If you participate in the Benefit Plan, you may elect to reduce your salary so that your share of the premiums for the Benefit Plan are paid using pre-tax dollars. Additionally, you may elect to contribute to a Qualified Medical Flexible Spending Account or a Qualified Dependent Care Flexible Spending Account. Eligible Employees who do not participate in this Plan may not pay any required contributions to the Benefit Plan with pre-tax dollars, nor may they pay Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses using pre-tax dollars.

Unless you experience a change in circumstances, as described below, your Salary Contribution Agreement will continue in force for that Plan Year, and you will be required to complete a new Salary Contribution Agreement for each subsequent Plan Year for which you decide to participate in this Plan.

If you do not submit the Salary Contribution Agreement to the Plan Administrator within 30 days of becoming eligible, or during the Annual Enrollment Period, it will be assumed that you have decided not to participate in the Plan, and you will not have the opportunity to enroll until the next Annual Enrollment Period or following a change in status event described below.

May I elect not to participate in the Benefit Plan?

You may elect not to participate in the Benefit Plan by completing and filing an appropriate election/declination form with the Plan Sponsor within 30 days of your original eligibility period or an Annual Enrollment Period.

Mid-Year Changes to Your Plan Elections

Generally, you cannot change your election to participate in the Plan or decrease or increase the amount you have elected to contribute to your account(s) once the Plan Year begins. However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your Spouse, or your Dependent, and the election change you make is consistent with the change in status event. Change in status events include:

- (1) Marriage.
- (2) Divorce, legal separation, or annulment.
- (3) Birth, adoption, or placement for adoption of a child.
- (4) Death of a Spouse or Dependent.
- (5) Termination or commencement of employment by you, your Spouse, or your Dependent.

- (6) Reduction or increase in hours of employment by you, your Spouse, or your Dependent which results in a change in eligibility under the Plan (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).
- (7) Place of residence change by you, your Spouse, or your Dependent, which results in a change in eligibility.
- (8) Your Dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of age, Student status, or any similar circumstance that would make the Dependent ineligible under Code § 152.
- (9) Commencement or return from an unpaid leave of absence by you, your Spouse, or your Dependent.
- (10) A change under another Employer Plan (including a Plan of your Employer or of another Employer); provided the other Employer sponsored Plan permits such mid-year election change.
- (11) A change in worksite of you, your Spouse, or your Dependent.
- (12) The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your Spouse, or your Dependent.
- (13) An election change by the Participant's Spouse or Dependent (or an election made on behalf of such Dependent by any other person) under another Employer-sponsored Plan if the Employee's election is on account of and corresponds with the Spouse's or Dependent's election and either of the following events occur:
 - (a) The election change by the Spouse or Dependent satisfies the regulations under Code §125 regarding permitted election changes; or
 - (b) The Spouse's or Dependent's election is for a period of coverage under the Plan maintained by the other Employer which does not correspond to the Plan Year of this Plan.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the Plan Administrator within 30 days of your change in status, as well as a new Salary Contribution Agreement reflecting your new contribution elections. The Plan Administrator reserves the right to require you to submit proof of any change in status at your expense. The change in coverage becomes effective with the first pay period following the date the written notification is received by the Plan Administrator, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event. Any such change will remain in effect for the remainder of the Plan Year.

Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy

If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

Must the election change be consistent with the change in status?

You will be permitted to change an election during the Plan Year and make a new election for the remainder of the Plan Year only if the change you make is consistent with the event. For example, you can only change your election to contribute to the Premium Only Plan or the Qualified Medical Flexible Spending Account if:

- (1) The change in status results in you or your Spouse or Dependent child, gaining or losing eligibility for health coverage under the Benefit Plan or another health Plan of your Spouse's or Dependent child's Employer; and
- (2) The election change corresponds with that gain or loss of coverage.

Changes in the Cost of Coverage During the Plan Year

If the Benefit Costs increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participant's elective contributions for the Premium Only Plan.

If there is a significant change in Benefit Costs or a significant change in your coverage under the Benefit Plan (as determined by the Plan Sponsor), you may make a corresponding change in your election to participate in the Premium Only Plan.

If the cost of your Qualified Dependent Care Flexible Spending Expenses significantly increase or decrease (as determined by the Plan Sponsor), and such increase or decrease is imposed by your Dependent care provider, then you may make a corresponding change in your election to participate in the Dependent care flexible spending account, provided any amounts paid to your Dependent care provider are not considered a payment made to an individual you are related to, as determined in accordance with Code §129(f).

May I continue participation during FMLA leave?

If the leave of absence is qualified under FMLA you have the option to terminate your participation or continue your participation in the Plan and make payments in a manner determined by the Plan Administrator, in its sole discretion, from among the following options:

- (1) Pre-Payment: You may prepay the contributions that will become due during your FMLA leave. Under this option, you may take contributions on a pre-tax basis from any available compensation.
- (2) Pay-As-You-Go: You may pay the contributions that become due during your FMLA leave on the same schedule as they would otherwise be taken from your pay, on the schedule for COBRA payments, under the Employer's existing rules for payment, or on any other schedule agreed upon by you and the Plan Administrator.
- (3) Catch-Up: The Plan Sponsor may advance the contributions on your behalf, and may recoup the contributions upon your return from FMLA leave.

Note: The Pre-Payment and the Catch-Up option may not be offered without also offering the Pay-As-You-Go option.

FMLA leave is treated as a change in status. Therefore, when beginning and/or returning from a qualified leave, you must complete a change in status form.

Continuation of Coverage under USERRA

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's Annual Enrollment Period, and pay your contributions in accordance with the options outlined above for a Participant who goes on FMLA leave.

When does my participation end?

If you terminate employment with the Employer, your participation in this Plan will terminate on the last day you are actively at work unless you elect to continue your participation in accordance with the guidelines provided in the "COBRA continuation coverage" section. Any Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses Incurred during the Plan Year prior to the date of termination will be reimbursed by the Plan in accordance with the guidelines in the section, "Benefits." Your participation in this Plan will also terminate if the Employer decides to terminate this Plan, or if you voluntarily decide not to participate under the terms of this Plan.

If your participation in this Plan terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the Plan for the remainder of the Plan Year or continue your participation in accordance with the "COBRA continuation of coverage" section. If you do not make payments as required under COBRA, it will be assumed that you elected to revoke your participation in this Plan.

Rehire Provision

If your employment terminates, and you return to eligible employment with your Employer within 30 days, you may rejoin the Plan provided that you keep your original election for that Plan Year. If your employment terminates, and you return to eligible employment with your Employer more than 30 days following termination of your participation, you may rejoin the Plan and make a new election after you satisfy the eligibility requirements for the remainder of the Plan Year, as long as the termination was not for the purpose of altering the original election.

If you do not complete and file a Salary Contribution Agreement during the Annual Enrollment Period, your participation will end at the end of the Plan Year.

COBRA continuation of coverage for contributions to a Qualified Medical Flexible Spending Account

If you are a Participant in the Plan, you, your Spouse or your dependents may be eligible for continued coverage under COBRA for contributions made to a Qualified Medical Flexible Spending Account. COBRA may give you the right to continue your benefits under a Qualified Medical Flexible Spending Account beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by you. Coverage will end in certain instances, including if you fail to make timely payment of premiums. Generally, COBRA applies to Employers with 20 or more Employees. You should check with your Employer to see if COBRA applies to you.

Qualifying Event

You may elect COBRA coverage if a Qualifying Event occurs and results in a loss of participation in the Qualified Medical Flexible Spending Account component of the Plan, such as:

- (1) The death of the Participant.
- (2) The termination of the Participant's employment (other than by reason of the Participant's gross misconduct) or reduction in the Participant's hours of employment.
- (3) The divorce or legal separation of the Participant from his Spouse.
- (4) A Dependent child ceases to be a Dependent under the terms of the Plan.
- (5) The Participant becomes entitled to Medicare benefits (under Part A, Part B or both).

You may not elect COBRA to continue coverage under the Premium Only Plan or the Qualified Dependent Care Flexible Spending Account component of the Plan.

In the event that the COBRA premium for the remainder of the Plan Year exceeds the maximum benefit still available under the Qualified Medical Flexible Spending Account as of the date of the Qualifying Event, the Plan Administrator has the option to either not offer COBRA continuation coverage, or offer the coverage for the remainder of the Plan Year.

Qualified Beneficiaries

The following people are known as qualified beneficiaries and may elect COBRA coverage that will include the benefits to which they were entitled to under the Plan on the day before one of the above Qualifying Events:

- (1) The Spouse or any Dependent child of the Participant under the Plan.
- (2) The Participant, if the Qualifying Event is the termination of coverage due to termination of employment or reduction in hours.

If a Dependent under the Plan who is also a qualified beneficiary has a newborn child, adopts a child, or a child is placed for adoption with that Dependent, that child will be entitled to the same COBRA coverage period, but will not become a qualified beneficiary in his own right.

If you have a newborn child, adopt a child, or a child is placed for adoption with you, that child will become a qualified beneficiary in his or her own right.

Notice Requirement

For Qualifying Events such as divorce, legal separation or change in Dependent status, you must inform the Plan Administrator of the event within 30 days of the event. For Qualifying Events such as death, termination or reduction in hours, entitlement to Medicare, bankruptcy or failure to return from leave under the FMLA, the Employer has 30 days from the date of the Qualifying Event, or the date that you will lose coverage due to the Qualifying Event, in which to notify the Plan Administrator. The Plan Administrator has the obligation to furnish you, your Spouse and your dependents, if they are eligible to receive benefits under this Plan, with separate, written options to continue coverage within 14 days of receiving notice of the Qualifying Event.

You must notify the Plan Administrator within 30 days of a child's birth, adoption, or placement for adoption in order to add the child to the continuation coverage.

Payment for COBRA Continuation Coverage

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period. This contribution will be on an after-tax basis.

How long may coverage be continued?

If you have experienced a Qualifying Event and have a positive balance in your Qualified Medical Flexible Spending Account at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in this Plan under COBRA. Your COBRA coverage period ends on the last day of the Plan Year in which the Qualifying Event occurs.

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

BENEFITS

Qualified Medical Flexible Spending Expenses

Qualified Medical Flexible Spending Expenses are Health Care Expenses which are excludable as income according to Code § 105(b). Qualified Medical Flexible Spending Expenses may not be otherwise reimbursable under the Benefit Plan or other Plan or by any other entity, and they may not be claimed as a tax deduction by the Participant. Qualified Medical Flexible Spending Expenses do not include the cost of insurance premiums.

Qualified and Non-Qualified Medical Flexible Spending Expenses

The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of Qualified Medical Flexible Spending Expenses will be in accordance with those expenses Incurred for medical care, as defined in Code § 213(d) of the Internal Revenue Code as stated at the time the expense is Incurred.

Examples of Qualified Medical Flexible Spending Expenses include:

- (1) Acupuncture
- (2) Alcoholism treatment
- (3) Allergy tests and shots
- (4) Ambulance services
- (5) Artificial limbs
- (6) Automobile modifications required by medical conditions
- (7) Birth control pills
- (8) Braille materials (books and magazines)
- (9) Chiropractic services
- (10) Co-payments
- (11) Contact lenses and supplies
- (12) Crutches
- (13) Deductibles on your and your Spouse's group Plan
- (14) Dental services (not cosmetic)
- (15) Dentures
- (16) Eyeglasses, including examination fees
- (17) Healing services
- (18) Hearing aids and batteries
- (19) Hospital costs not covered by a group health Plan
- (20) Insulin

- (21) Laboratory fees
- (22) Laetrile by prescription
- (23) Mental health care and fees
- (24) Nurses' fees
- (25) Obstetrical expenses
- (26) Orthodontic services, if medically necessary
- (27) Orthopedic shoes prescribed by a physician
- (28) Osteopaths' fees
- (29) Over-the-counter drugs and medicines are eligible expenses only if they qualify as Health Care Expenses and only if you have a valid prescription from a licensed provider
- (30) Oxygen
- (31) Physicians' fees not covered by medical Plan
- (32) Podiatrists' fees
- (33) Prescription drugs
- (34) Radial keratotomy
- (35) Ramps required by medical conditions
- (36) Rental of medical equipment
- (37) Routine physical examinations
- (38) Seeing eye dogs and their upkeep
- (39) Smoking cessation programs, only if monitored by a licensed practitioner
- (40) Special communications equipment for the deaf
- (41) Therapeutic care for substance abuse (drug or alcohol)
- (42) Weight loss programs prescribed by physicians for specific health problems
- (43) Wheelchairs

Examples of non-Qualified Medical Flexible Spending Expenses include:

- (1) Cosmetic Surgery, except those procedures necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- (2) Funeral expenses
- (3) Health insurance premiums

- (4) Massage therapy
- (5) Maternity clothes
- (6) Nursing home expenses
- (7) Over-the-counter drugs and medicines (other than insulin) obtained without a valid prescription from a licensed provider
- (8) Weight loss programs prescribed by physicians for general health improvement

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Internal Revenue Code §§ 105(b) and 213(d) as stated at the time the expense is Incurred.

Carryover of Unused Funds

If you have an unused balance remaining in your Qualified Medical Flexible Spending Account at the end of the Plan Year (and after all reimbursement requests for the Plan Year have been processed), a portion or all of your unused balance will carry over for use in the following Plan Year, up to a maximum carryover amount of \$500, but only if you are still a Participant for purposes of the Qualified Medical Flexible Spending Account on the last day of the Plan Year.

Reimbursement for Qualified Medical Flexible Spending Expenses is limited to the total amount you elected under your Salary Contribution Agreement to contribute to your Qualified Medical Flexible Spending Account for the Plan Year plus, if applicable, any amount carried over from the previous year. It is important to keep in mind that you cannot use amounts contributed to a Qualified Dependent Care Flexible Spending Account to pay Qualified Medical Flexible Spending Expenses.

Participation in a Health Reimbursement Arrangement (HRA)

If you also participate in a health reimbursement arrangement under Code §§ 105 and 106 offered by the Plan Sponsor, you must first exhaust the amount available for the reimbursement of Qualified Medical Flexible Spending Expenses under this Plan before seeking reimbursement for such Qualified Medical Flexible Spending Expenses under the health reimbursement account.

Qualified Reservist Distribution (QRD)

Eligible Employees that are members of a reserve component of the U.S. military and are ordered or called to active duty for 180 days or more may request a distribution of his or her medical flexible spending account up to a maximum of the amount he or she contributed as of the date of such QRD request minus any reimbursements received as of the date of the QRD request.

An Eligible Employee's right to submit claims for qualified medical flexible expenses Incurred after the date of such QRD request shall be suspended for the remainder of the Plan Year.

Any QRD requests must be submitted to the Plan Administrator no earlier than the date on which such Eligible Employee is ordered or called to active duty and not later than the last day of such Plan Year. The QRD request must include a copy of the Eligible Employee's order or call to active duty specifying the period of active duty.

Please contact the Plan Administrator for information on Qualified Reservist Distributions.

Qualified Dependent Care Flexible Spending Expenses

If you have elected to contribute to a Dependent care flexible spending account, the Plan will reimburse you for Qualified Dependent Care Flexible Spending Expenses which are Incurred by you during the Plan Year.

Reimbursement for Qualified Dependent Care Flexible Spending Expenses is limited to the annualized amount you elected under your Salary Contribution Agreement to contribute to a Qualified Dependent Care Flexible Spending Account for the Plan Year. It is important to keep in mind that you cannot use amounts contributed to a Qualified Medical Flexible Spending Account to pay Qualified Dependent Care Flexible Spending Expenses.

What are Qualified Dependent Care Flexible Spending Expenses?

Qualified Dependent Care Flexible Spending Expenses are employment-related Dependent care expenses eligible for reimbursement under the Plan as determined under Code §§ 129(e) (1) and 21(b). Such expenses include amounts paid for daycare and other household services and for the care of Qualifying Individuals enabling you to be gainfully employed.

What are Examples of Qualified and Non-Qualified Dependent Care Flexible Spending Expenses?

The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of eligible expenses will be in accordance with Code §§ 21 and 129, as stated at the time the expense is Incurred.

Examples of Qualified Dependent Care Flexible Spending Expenses include:

- (1) Fees of a licensed Dependent Care Center that cares for your Dependent child.
- (2) After-school care expenses.
- (3) Wages of individuals who provide care inside or outside your home for your Dependent child under age 13 or a Qualifying Individual over age 13 who is incapable of self-support.
- (4) Federal and state employment taxes you pay for an individual you employ to provide Dependent care.
- (5) Day camps.
- (6) Pre-school or nursery school tuition.

Examples of non-Qualified Dependent Care Flexible Spending Expenses include:

- (1) Educational expenses for a child in kindergarten or above.
- (2) Transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.
- (3) Household expenses that are not attributable at least in part to the care of the Qualifying Individual.
- (4) Expenses for a camp where a Qualifying Individual spends the night.

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Code §§ 21 and 129, as stated at the time the expense is Incurred.

Benefit Costs

By electing to participate in the Premium Only Plan, your portion of the Benefit Costs will be taken out of your salary and paid using pre-tax dollars.

Debit Card Feature

Qualified Medical Flexible Spending Expenses may be purchased directly from the merchant or provider of services through the use of a Debit Card. Similarly, Qualified Dependent Care Flexible Spending Expenses may be purchased directly from the provider of services through the use of a Debit Card. This is a very convenient way to access the benefits of the Plan. Here is how the Debit Card feature works:

When you enroll in the Plan each year, you must certify that the Debit Card will only be used for either Qualified Medical Flexible Spending Expenses, as defined in Code § 213(d) or Qualified Dependent Care Flexible Spending Expenses, as defined above. You must also certify that you will not pay any expense with the Debit Card that has been reimbursed and that you will not seek reimbursement for the expense under any other Plan covering health benefits or Dependent care, respectively. The certification will be printed on your Debit Card, and by using the card, you will reaffirm the certification each time you use the Debit Card.

When you use the Debit Card at the point-of-sale, the merchant or provider of service is paid the full amount of either the Qualified Medical Flexible Spending Expense or the Qualified Dependent Care Flexible Spending Expense (assuming there is sufficient coverage in your account), and your maximum available coverage remaining is reduced by that amount. Your use of the Debit Card is limited to the maximum dollar amount of coverage available in your Qualified Medical Flexible Spending Account or your Qualified Dependent Care Flexible Spending Account.

Your Debit Card is ineffective except at those merchants and providers of service authorized by the Plan, so that the use of the card at other merchants or service providers will be rejected. The Plan limits the Debit Card's use to specify Merchant Codes relating to covered health care or Dependent care. Thus, the Debit Card's use is limited to physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers of service or providers of Dependent care service.

Your Debit Card can be used to pay for over-the-counter medicine or drugs from your Qualified Medical Flexible Spending Account at drug stores and pharmacies (and at non-health care merchants that have pharmacies, and at mail order and web-based vendors that sell prescription drugs) only if the following requirements are met:

- (1) Prior to purchase, (i) the prescription for the over-the-counter medicine or drug is presented to the pharmacist; (ii) the over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law; and (iii) an Rx number is assigned;
- (2) The pharmacy or other vendor retains, in a manner that meets IRS's recordkeeping requirements: (i) the Rx number; (ii) the name of the purchaser or person for whom the prescription applies; and (iii) the date and amount of the purchase;
- (3) All of these records are available to the Employer upon request;
- (4) The Debit Card system will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned; and
- (5) The use of the Debit Card complies with all applicable regulations and other authoritative guidance regarding the use of Debit Cards for Qualified Medical Flexible Spending Account reimbursements, including substantiation requirements.

In addition, your Debit Card may also continue to be used to purchase over-the-counter medicines or drugs from vendors other than those described above that have health care-related "Merchant Codes" as described in Rev. Rul. 2003-43, including physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers. If all other requirements in the preceding paragraph are satisfied, then these Debit Card transactions will be considered fully substantiated.

Your Debit Card may continue be used to purchase over-the-counter medicines and drugs at "90% pharmacies" with at least 90% of the store's gross receipts during the prior tax year consisting of qualified medical care expenses under Code Sec. 213(d).

For all other providers and merchants, you will have to file a paper claim reimbursement form.

You must agree to acquire and retain sufficient documentation for any expense paid with the Debit Card, including invoices and receipts where appropriate. All charges to the Debit Card are treated as conditional pending confirmation of the eligibility of the charge through your documentation. Within 90 days of using your Debit Card, you must submit an invoice or receipt from the merchant or provider of service, including the information required under either Sections "How do I file a claim for Qualified Medical Flexible Spending Expenses" or "How do I file a claim for Qualified Dependent Care Flexible Spending Expenses" as applicable.

Substantiation of Qualified Medical Flexible Spending Expenses will be satisfied without additional documentation when:

- (1) The dollar amount of the transaction at a health care provider exactly equals the dollar amount of the copayment under the Benefit Plan for that service;
- (2) The expense is a recurring expense that exactly matches a previously approved Qualified Medical Flexible Spending Expense at this provider for the same time period;
- (3) Verification is provided to the Plan through "real-time substantiation" that the expense is a Qualified Medical Flexible Spending Expense by the provider of service, merchant or independent third party (e.g., Pharmacy Benefit Manager).

Substantiation of Qualified Dependent Care Flexible Spending Expenses will be satisfied without additional documentation when:

- (1) The expense is a recurring expense that exactly matches a previously approved Qualified Dependent Care Flexible Spending Expense at this provider for the same time period; and
- (2) Verification is provided to the Plan through "real-time substantiation" that the expense is a Qualified Dependent Care Flexible Spending Expense by the provider of service, merchant or independent third party.

You should verify that the Plan Administrator considers any expenses substantiated.

If the Plan Administrator finds that any claims have been paid that are not for Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses, you are required to refund any amount so identified to the appropriate account. If you fail to promptly refund the overpayment to the Plan, the amount may be withheld from your wages or other compensation to the extent permitted by law. In addition, the Plan reserves the right to suspend your use of the Debit Card and/or credit the overpayment against other Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses, that you may submit until the overpayment refund is satisfied. Amounts overpaid for Qualified Medical Flexible Spending Expenses will not be credited against Qualified Dependent Care Flexible Spending Expenses and vice versa.

Your Debit Card will automatically be cancelled if your employment terminates or if your participation in the Plan otherwise terminates.

Must I File a Claim for Benefits Under the Premium Only Plan?

No, it is not necessary to file a claim for benefits under a Premium Only Plan.

How do I file a Claim for Benefits under a Qualified Medical Flexible Spending Account if it is not a self substantiating debit charge?

You must submit a properly completed and documented claim to:

Meritain Health, Inc.
P.O. Box 30111
Lansing, MI 48909
Fax: (888) 837-3725
Phone: (800) 566-9305

It must include the following information:

- (1) The name of the person or persons on whose behalf the expenses have been Incurred.
- (2) The nature of the expenses Incurred (that is, a description of the services or supplies being claimed).
- (3) The date the expenses were Incurred.

- (4) Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any Benefit Plan, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letter(s) from the Benefit Plan(s). Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved by the Plan Administrator certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are eligible for reimbursement under the Plan.

The Plan Administrator, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this Plan.

The Plan will pay properly submitted claims for reimbursement at such intervals as the Plan Administrator may consider appropriate.

How do I File a Claim for Benefits under a Qualified Dependent Care Flexible Spending Account if it is not a self substantiating debit charge?

You must submit a properly completed and documented claim to:

Meritain Health, Inc.
P.O. Box 30111
Lansing, MI 48909
Fax: (888) 837-3725
Phone: (800) 566-9305

It must include the following information:

- (1) A list of names of the eligible Qualifying Individual for whom the expenses were incurred, the ages of such Qualifying Individual, and the Qualifying Individual's relationship to you.
- (2) If any of the services were performed outside of your home for a Qualifying Individual incapable of caring for himself, a statement as to whether the Qualifying Individual regularly spends at least eight hours a day in your home.
- (3) If any of the services are performed for a Qualifying Individual who is physically or mentally incapable of caring for himself, a statement to that effect.
- (4) A description of the nature and dates of performance of the qualifying services for which cost you wish to be reimbursed.
- (5) A description of the relationship, if any, to you of the person or persons who performed the services.
- (6) A statement indicating that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt Dependent care facility) the taxpayer identification number of the provider of the services.
- (7) If you are married, a statement as to whether you plan to file a separate federal income tax return from your Spouse.
- (8) If you are married, and your Spouse is employed, a statement of your Spouse's compensation.

- (9) If you are married and your Spouse is not employed, a statement that your Spouse is incapacitated, or that your Spouse is a Student, and indicating the months of the year during which the Spouse attends an educational institution on a full-time basis.
- (10) A statement as to the amount, if any, of tax-exempt Dependent care assistance benefits received from any other Employer for you or your Spouse during the Plan Year.
- (11) Evidence of indebtedness or payment by you to the third party who performed the services.
- (12) Written evidence, signed by an independent third party stating that the expenses have been Incurred, the amount of such expenses, the date of services, and such other information as the Plan Administrator in its sole discretion may request.
- (13) A statement as to where the services were performed.
- (14) A statement indicating whether the services are necessary to enable you to be gainfully employed.
- (15) A statement that the expenses have not been reimbursed and are not reimbursable under any other Plan or by any other entity.
- (16) A statement, signed by you and in such form as determined by the Plan Administrator, certifying that the expenses for which reimbursement is sought are expenses that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care provider or from the individual who provides the care. The social security number or the federal tax identification number of the provider **must** appear on the claim form or receipt. The individual who provides the care cannot be your Spouse or a Dependent under the age of 19.

The Plan Administrator, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this Plan.

The Plan will pay properly submitted claims for reimbursement at such intervals as the Plan Administrator may consider appropriate.

Timely Filing

All claims for reimbursement must be submitted within 60 days following the end of the Plan Year, or the claims will be denied.

Minimum Claim Amount

There is not a minimum claim amount for the Qualified Medical Flexible Spending Account or the Qualified Dependent Care Flexible Spending Account.

What if My Qualified Medical Flexible Spending Account Balance or my Qualified Dependent Care Flexible Spending Account Balance is Less Than my Claim?

Reimbursement for Qualified Medical Flexible Spending Expenses is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the Qualified Medical Flexible Spending Account for the Plan Year under a valid Salary Contribution Agreement. Reimbursement for Qualified Dependent Care Flexible Spending Expenses is limited to the amount that you have elected to reduce your salary or wages to contribute to the Qualified Dependent Care Flexible Spending Account for the Plan Year under a valid Salary Contribution Agreement for that Plan Year.

To the extent that it is not used to pay claims, the amount of contributions to your Qualified Medical Flexible Spending Account will accumulate throughout the Plan Year. If you submit an eligible claim during the Plan Year in an amount that exceeds your current Qualified Medical Flexible Spending Account balance, the Plan will reimburse your claim expense up to the annualized amount of contributions, less any amounts already used to pay claims. Your salary contribution election amount will continue to be taken for the remainder of the Plan Year.

To the extent that it is not used to pay claims, the amount of contributions to your Qualified Dependent Care Flexible Spending Account will also accumulate throughout the Plan Year. If you submit an eligible claim during the Plan Year in an amount that exceeds your current Qualified Dependent Care Flexible Spending Account balance, the Plan will reimburse your claim expense up to the total amount of contributions in your Qualified Dependent Care Flexible Spending Account, less any amounts already used to pay claims. As contribution amounts become available in your Qualified Dependent Care Flexible Spending Account, they may be used to reimburse any unpaid balance from a previously submitted Qualified Dependent Care Flexible Spending Expense. At no time during the Plan Year will the amount paid for claims exceed the amount of contributions made to the Qualified Dependent Care Flexible Spending Account.

In no instance can amounts contributed to a Qualified Medical Flexible Spending Account be used to reimburse Qualified Dependent Care Flexible Spending Expenses, or vice versa.

What if I do not use all of the money in my Qualified Medical Flexible Spending Account or my Qualified Dependent Care Flexible Spending Account?

You have 60 days following the end of the Plan Year to submit a claim for reimbursement for any Qualified Medical Flexible Spending Expenses and Qualified Dependent Care Flexible Spending Expenses Incurred during that Plan Year, or if earlier, 60 days following the end of the Plan Year following the date you cease to participate in the applicable spending account. Claims submitted after that time has passed will be denied. Any amount remaining in a flexible spending account after all timely submitted claims for reimbursement have been processed will be forfeited, except for any amount that may be carried over to a Qualified Medical Flexible Spending Account for the next Plan Year (as described under "Carryover of Unused Funds"). No carryover provision applies to Dependent care flexible spending accounts.

FUNDING

Funding the Qualified Medical Flexible Spending Account

Your Qualified Medical Flexible Spending Account is funded by the amounts that you elect to contribute to the account by executing a valid Salary Contribution Agreement. Qualified Medical Flexible Spending Expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the Plan Year under a valid Salary Contribution Agreement.

Your annual salary or wage may be reduced in an amount not to exceed \$2,650 or any other amount established by the Plan Sponsor for each Plan Year and communicated to you prior to the Annual Enrollment Period. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the Plan Year.

The Plan Administrator will establish an individual Qualified Medical Flexible Spending Account for each Participant, and will credit to each Participant's account the salary contribution amounts elected.

The Plan will reimburse you for Qualified Medical Flexible Spending Expenses as described in the "Benefits" section.

Funding the Qualified Dependent Care Flexible Spending Account

Qualified Dependent Care Flexible Spending Expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the Plan Year under a valid Salary Contribution Agreement, not to exceed the amount in your account at the time reimbursement is requested.

Your salary or wage may be reduced in an amount you elected under the Salary Contribution Agreement. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the Plan Year.

The Plan Administrator will establish an individual Qualified Dependent Care Flexible Spending Account for you and will credit to your account the amounts taken out of your pay for each pay period.

The Plan will reimburse you for Qualified Dependent Care Flexible Spending Expenses as described in the "Benefits" section.

How much can I elect to contribute to my Qualified Dependent Care Flexible Spending Account?

If you are not married you may contribute up to \$5,000 to a Qualified Dependent Care Flexible Spending Account; however, in the event that your Earned Income is less than \$5,000, you may contribute an amount not to exceed your Earned Income for the taxable year. If you begin participation in the middle of the Plan Year you may contribute up to \$5,000 less any amounts that you have contributed to any other Qualified Dependent Care Flexible Spending Account during the Plan Year.

If you are married, you may contribute an amount up to the lesser of the Earned Income of you or your Spouse, not to exceed \$5,000. If you and your Spouse file separate tax returns, you may elect to contribute an amount up to \$2,500 to the Plan. If you begin participation in the middle of the Plan Year you may contribute up to \$5,000, or \$2,500 if you and your Spouse file separately, less any amounts that you have contributed to any other Qualified Dependent Care Flexible Spending Account during the Plan Year.

If your Spouse is a full-time Student, for each month in which he is a full-time Student, for the purpose of determining how much you can contribute under this Plan, he will be considered to be gainfully employed, and to have Earned Income of not less than \$250 per month if there is one Qualifying Individual with respect to the taxpayer for the taxable year and not less than \$500 per month if there are two or more Qualifying Individuals with respect to the taxpayer for the taxable year.

If your Spouse is a Qualifying Individual, for the purpose of determining how much you can contribute under this Plan, he will be considered to be gainfully employed, and to have Earned Income of not less than \$250 per month if there is one Qualifying Individual with respect to the taxpayer for the taxable year and not less than \$500 per month if there are two or more Qualifying Individuals with respect to the taxpayer for the taxable year.

Minimum Election Amounts

There is no annual election contribution requirement for the Qualified Medical Flexible Spending Account. There are no annual election contribution requirements for the Qualified Dependent Care Flexible Spending Account.

How is a Premium Only Plan funded?

The Premium Only Plan is funded by your contributions under a Salary Contribution Agreement with the Employer. The contribution amounts paid under the Salary Contribution Agreement will be adjusted automatically during a Plan Year to reflect changes in the Benefit Cost.

Order of Funding

The total salary contribution amount for this Plan for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: the Premium Only Plan, the Qualified Medical Flexible Spending Account, then the Qualified Dependent Care Flexible Spending Account. The total salary contribution amount will be reduced by the amount it exceeds your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting

The Plan Administrator will maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses on behalf of each Participant. All contributions will be held as part of the general assets of the Employer. No trust fund will be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this Plan.

SALARY CONTRIBUTION AND DISCRIMINATION

Election Period for Salary Contribution

To participate in a Qualified Medical Flexible Spending Account, Qualified Dependent Care Flexible Spending Account, or to pay for health coverage for a Plan Year, you must complete and file with the Plan Administrator an appropriate Salary Contribution Agreement election form as described in the section, "Eligibility for Participation." You should carefully consider the amount you elect to contribute for either of these accounts because federal tax law requires that you forfeit any unused amount if you do not incur enough eligible expenses during the Plan Year except for any amount that may be carried over to a Qualified Medical Flexible Spending Account for the next Plan Year (as described under "Carryover of Unused Funds").

Termination, Revocation, or Amendment of Salary Contribution Elections

Your Salary Contribution Agreement election for a Plan Year will terminate at the end of the Plan Year. You must make an affirmative election for a new salary contribution for each Plan Year.

Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, "Eligibility for Participation," "May I make mid-year changes?"

Forfeiture of Salary Contribution Amounts

If you fail to claim any amounts in the Qualified Medical Flexible Spending Account, Qualified Dependent Care Flexible Spending Account, or Premium Only Plan within the time limits specified in the section, "Benefits," "Is There a Time Limit for Filing Claims?," such amounts will be forfeited by you to the Plan Sponsor.

Distribution of Excess Contributions under the Premium Only Plan

Under the Premium Only Plan component only, all monies held by the Employer attributable to salary or wage contribution amounts to pay for a Participant's Benefit Cost which are in excess of such Benefit Costs for a Plan Year, will be forfeited by the Participant to the Plan Sponsor at the end of the relevant Plan Year. The Plan Sponsor may use excess contributions to uniformly decrease the Benefit Costs of all Participants in the next Plan Year. If applicable, no amount will be forfeited at the end of the Plan Year for a Health Savings Account.

Reduction of Salary Contribution Elections to Prevent Discrimination in Favor of Prohibited Group(s)

The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits and is intended to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such highly compensated individuals who are Participants, and/or reduce contributions under the Plan by highly compensated individuals who are Participants, to the extent necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

The Plan Administrator will have the full authority to reduce the salary contribution elections of Participants who are members of the prohibited group(s) under Code §§ 105(h) or 125, to the extent necessary to prevent the Plan from discriminating in favor of such prohibited group(s).

Determination of Non-Compliance

In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions to a "cafeteria Plan" under Code § 125, the affected contributions made by any Participant will be treated as salary, and any unpaid balance in the Qualified Medical Flexible Spending Expense account, the Qualified Dependent Care Flexible Spending Account and the Premium Only Plan will be returned to the Participant. The Participant must pay:

- (1) Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed;

- (2) The Participant's share (as determined in good faith by the Employer) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the Employer had such amounts been treated as salary and not as Qualified Medical Flexible Spending Expenses, Qualified Dependent Care Flexible Spending Expenses, or Benefit Costs; and
- (3) An amount (as determined in good faith by the Employer) equal to the portion of any applicable penalties and interest payable by the Employer as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the Participant.

PLAN ADMINISTRATION

Authority to Make Decisions

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the third party administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are not Qualified Medical Flexible Spending Expenses, Qualified Dependent Care Flexible Spending Expenses, or Benefit Costs), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

The duties of the Plan Administrator include the following:

- (1) To administer the Plan in accordance with its terms;
- (2) To determine all questions of eligibility, status and coverage under the Plan;
- (3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- (4) To make factual findings;
- (5) To decide disputes which may arise relative to a Participant's rights;
- (6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- (7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (8) To appoint and supervise a third party administrator to pay claims;
- (9) To perform all necessary reporting as required by Federal or State law;
- (10) To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
- (11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- (12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Additional Operating Rules

A Participant's salary contribution amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary contribution amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

Salary contribution amounts under this Plan shall not reduce salary or wage for purposes of any other Employer sponsored Employee benefit programs unless the provisions of those programs otherwise provide.

MISCELLANEOUS INFORMATION

Release of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the Privacy Standards. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that it has determined that the Plan Administrator has mistakenly reimbursed an expense which did not qualify under the terms of the Plan, the Plan Administrator may adjust your pay and appropriately credit the Qualified Medical Flexible Spending Account, Qualified Dependent Care Flexible Spending Account or Premium Only Plan.

Conformity with Applicable Laws

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Statute of Limitations for Plan Claims

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the Benefit Costs, Qualified Medical Flexible Spending Expenses or Qualified Dependent Care Flexible Spending Expenses are Incurred or are alleged to have been Incurred. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claims Review Procedures."

Fraudulent or Misleading Information

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this Plan:

- (1) Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your Spouse or your Dependent according to the Plan;
- (2) Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- (3) Providing false or misleading information in connection with enrollment in the Plan; or
- (4) Providing any false or misleading information to the Plan.

Interpretation of this Document

The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Summary Plan Description are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Summary Plan Description applies to Participants.

No Contract of Employment

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Summary Plan Description shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Appointing an Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the third party administrator. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

How will the Plan pay benefits?

All benefits under this Plan are payable, in U.S. Dollars, to the Participant or, if appropriate, the Alternate Recipient. In the event of the death or incapacity of a Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, the Plan Administrator may, in its sole discretion, make any and all payments due under the Plan to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such Participant.

Filing Claims for non-U.S. Providers

Qualified Medical Flexible Spending Expenses and Qualified Dependent Care Flexible Spending Expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. provider") may be reimbursed under the following conditions:

- (1) The Participant is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- (2) Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
- (3) The non-U.S. provider shall be subject to, and in compliance with, all requirements under Code § 105; and
- (4) Claims for benefits must be submitted to the Plan in English.

Recovery of Payments Made in Error

Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Participant on whose behalf such payment was made.

A Participant, Spouse, Dependent, provider, another Benefit Plan, insurer, or any other person or entity who receives a payment made in error under the terms of the Plan, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or other arrangement, as agreed.

Participants accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with the requirements of this Plan. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Medical Child Support Orders

The Plan Administrator shall adhere to the terms of any Medical Child Support Order that satisfies the requirements of this section and Section 609 of ERISA. The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a qualified medical support order if such an individual is not already covered by the Plan as a Dependent.

The Plan Administrator shall promptly notify the Participant and each Alternate Recipient of:

- (1) The receipt of a Medical Child Support Order by the Plan; and
- (2) The Plan's procedures for determining the qualified status of Medical Child Support Orders.

Within a reasonable period after receipt of a Medical Child Support Order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and shall notify the Participant and each Alternate Recipient of such determination. If the Participant or any affected Alternate Recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure provided in the section, "Claims Review Procedures," of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

- (1) Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the Plan, and if so:
 - (a) Whether the child is covered under the Plan; and
 - (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- (2) Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage. To give effect to this requirement, the Plan Administrator shall:
 - (a) Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or a National Medical Support Notice; and
 - (b) Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

Payments made under this Plan pursuant to a Medical Child Support Order described in this section in reimbursement for expenses paid by the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

Statement of Benefits

On or before January 31st of each year, the Plan Administrator will furnish each Participant who received benefits under the Plan a written statement showing the amounts paid or the expenses incurred by the Plan Sponsor in providing reimbursement under the Plan for Qualified Dependent Care Flexible Spending Expenses, Qualified Medical Flexible Spending Expenses, and Benefit Costs for the prior Plan Year.

CLAIMS REVIEW PROCEDURE

Upon receipt of complete information, the claim will be deemed to be filed with the Plan. The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Plan Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claims Decisions

The Plan Administrator shall notify you, in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

- (1) If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- (2) If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the Plan Administrator.

Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide you with a notice, either in writing or electronically, containing the following information:

- (1) A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
- (2) Specific reason(s) for a denial;
- (3) A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- (4) A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- (5) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- (6) The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- (7) Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to you, free of charge, upon request); and

- (8) In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- (1) You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- (2) You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- (3) For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- (4) For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- (5) That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- (6) For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
- (7) That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances.

Requirements for Appeal

You must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

Meritain Health, Inc.
Appeals Department
P.O. Box 1380
Amherst, NY 14226-1380

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- (1) The name of the Participant;

- (2) The Participant's social security number;
- (3) The group name or identification number;
- (4) All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
- (5) The claim amount
- (6) A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- (7) Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

- (1) The Plan Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- (2) Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide you with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- (1) The specific reason or reasons for the denial;
- (2) Reference to the specific portion(s) of the Summary Plan Description on which the denial is based;
- (3) The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- (4) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- (5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- (6) If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request;
- (7) A statement of your right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

- (8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide you access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 365 days after the Plan's claim review procedures have been exhausted.**

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage in the Qualified Medical Flexible Spending Account for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a daily penalty up to the statutory maximum amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, 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 would 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance 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.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- (2) Ensure that any agents , to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards;
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

- (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
- (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- (3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.
- (4) Report to the Plan any Security Incident of which it becomes aware.
- (5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.