FLEXIBLE BENEFIT PLAN with Beniversal® MasterCard® Prepaid Card
SUMMARY PLAN DESCRIPTION

Maximize Your Benefits
By taking advantage of this plan, you can make your benefits more affordable and increase your spendable income. Please take the time to carefully read this summary so that you understand the advantages of participating in this valuable program.

Take Advantage of the Tax Laws
Flexible Benefit Plans are made possible by Section 125 of the Internal Revenue Code. Congress created Section 125 to allow employees to save taxes on the money they spend on certain group insurance premiums (e.g. group health insurance), certain medical expenses not covered by insurance, certain dependent care expenses (e.g. child/adult day care), certain adoption expenses and Health Savings Account contributions.

How the Plan Works
If you participate in the plan, you can have money deducted from your pay tax-free to use for certain group insurance premiums. Your employer may also offer you the option of Flexible Spending Accounts, which enable you to pay for eligible medical expenses not covered by insurance, eligible dependent care expenses and eligible adoption expenses tax-free. With Flexible Spending Accounts, you choose the amount you want to have deducted from your pay and set aside to pay for your eligible expenses. If your employer offers a High Deductible Health Plan, your employer may also offer you the opportunity to contribute to a Health Savings Account with payroll deductions on a tax-free basis.

By participating in the Flexible Benefit Plan, you can pay for these benefits tax-free, meaning that you will not have to pay Federal income taxes, social security (FICA) taxes and most State income taxes on these amounts. Because you pay less tax, your spendable income increases. (Note: you will not have to pay Federal income taxes and most State income taxes on adoption assistance benefits.)

There is no separate fund or account where assets are accumulated to fund the plan, nor is there a policy of insurance from which claims are paid. The plan is funded from your employer's general assets for payment of group insurance premiums or for reimbursement of Flexible Spending Account claims. Health Savings Account contributions are immediately forwarded to the trustee/custodian to be placed in your individual account. The plan has a contract with Benefit Resource, Inc. to provide administrative services to process Flexible Spending Account claims on behalf of the plan.

Participating in the Plan
Only those employees who are eligible can participate in the plan. If you meet the requirements indicated in Section A of your Plan Highlights, you are eligible to participate. You will begin participation in the plan on the date indicated in Section A of your Plan Highlights. There may be further eligibility restrictions for certain insurance benefits, as described in the applicable insurance certificates or plan documents. There are also special eligibility criteria to make contributions to a Health Savings Account, as described below.

If the Plan Administrator reasonably believes that you knowingly submitted an expense which is not eligible for reimbursement from a Flexible Spending Account, the Plan Administrator may immediately discontinue your participation in the plan, prohibit you from again participating in the plan and assess a surcharge for ineligible expenses. The Plan Administrator may request from you any information reasonably necessary to assist in such determination. Your failure to provide such information shall be cause for the Plan Administrator to find that you knowingly submitted an expense that is not eligible.

Tax-Free Insurance Premiums
If you are eligible to participate and are already enrolled in any of the group insurance plans indicated in Section A of your Plan Highlights, you will be automatically enrolled in the plan, and your premiums will be deducted from your pay tax-free. However, participation is voluntary, and you may opt out of the tax-free premium feature of the plan by signing a waiver form and returning it to the Plan Administrator prior to the date indicated in Section A of your Plan Highlights or prior to the beginning of each new plan year.

If you do participate in this feature of the plan, the amounts deducted from your pay will go directly to the applicable insurance company in payment of your premiums. The insurance company will continue to pay your benefits in accordance with the policy. Remember, participating in the plan does not change your existing insurance coverage; it simply allows you to pay your insurance premiums tax-free.

Tax-Free Flexible Spending Accounts (FSAs)
If you want to use the plan to pay for eligible out-of-pocket expenses for medical services provided to you, your spouse or your eligible dependents, for eligible dependent care expenses or for eligible adoption expenses, you must enroll at the beginning of each new plan year in a Medical FSA, Dependent Care FSA and/or Adoption Assistance FSA. For a Medical FSA, eligible dependents may include your biological, adopted, step or foster children under age 26, and your other tax dependents. You will indicate how much you want to designate for each type of account, up to the maximum amounts indicated in Section B of your Plan Highlights. That amount will be deducted tax-free from your pay in equal installments and will go into the account(s) you have elected.

What Kinds of Expenses Can Be Paid Through the Medical FSA?
If you elect the Medical FSA, you can be reimbursed for many out-of-pocket expenses for eligible medical services provided to you, your spouse or your eligible dependents. For example, deductibles, co-payments and many other items not covered by your health insurance can be reimbursed through this account. For a more detailed list, please refer to the Medical Expense Worksheet. (Note: You cannot be reimbursed for any insurance premiums through your Medical FSA.)

What Kinds of Expenses Can Be Paid Through the Dependent Care FSA?
If you elect the Dependent Care FSA, you can be reimbursed for child or adult day care expenses, in-home dependent care expenses and nursery school expenses. In order to participate in this account, the Internal Revenue Code requires that the following criteria be met:

- The dependent care must enable you to be gainfully employed and, if married, enable your spouse to be gainfully employed, look for work or attend school full time.
- If your dependent is a child, he or she must be less than 13 years of age.
- If your dependent is physically or mentally incapable of self-care and has the same principal place of abode as you for half of the year, he or she must spend at least 8 hours per day in your home.

These and other applicable requirements are discussed in more detail on the Dependent Care Expense Worksheet. Before you enroll in the Dependent Care FSA, you should also consider whether or not it would be to your advantage to instead use the Federal tax credit for child and dependent care expenses, since you cannot claim the credit for any expenses reimbursed through this account.

What Kinds of Expenses Can Be Paid Through an Adoption Assistance FSA?
If you elect an Adoption Assistance FSA, you can be reimbursed for qualified expenses:

- which relate to reasonable and necessary adoption fees, court costs, and attorney fees;
- which are directly related to and for the principal purpose of the legal adoption of an eligible child who is under 18 years of age or physically or mentally incapable of self-care;
- which are not in violation of any State or Federal law;

- which are not in connection with any surrogate parenting arrangement;
- which are not in connection with a stepparent adoption.

Deciding How Much to Set Aside in a Flexible Spending Account
If you enroll in any of the Flexible Spending Accounts offered under the plan, you must carefully consider the amount you want to elect for each type of account. Keep in mind that if your actual expenses during the plan year exceed the amount you elect, you will only be reimbursed up to the amount of your election. If your actual expenses during the plan year are less than the amount you elect for that purpose, you should refer to Section B of your Plan Highlights regarding unused funds.

Because of these rules, you need to be as accurate as possible when you decide how much to elect for reimbursement. The Medical Expense Worksheet and Dependent Care Expense Worksheet can help you estimate the amount to elect for these accounts.

If your employer has elected to apply the grace period, you can generally be reimbursed for medical expenses provided during the plan year plus a grace period of up to 2 ½ months following the plan year. Section B of your Plan Highlights indicates if your plan allows the grace period.

If your employer has elected to apply the Medical FSA Rollover rule, as indicated in Section B of your Plan Highlights, you can generally carry over up to $500 of your unused Medical FSA contributions in one plan year to the following plan year.

Beniversal® Cards for the Medical FSA
Eligible Medical FSA expenses may be paid using a Beniversal Card at a qualified merchant. A Beniversal Card gives you the convenience of paying for eligible medical expenses directly, rather than having to pay the expense and then seek reimbursement. Please be sure to read the separate communication explaining the special rules and requirements that apply to your Beniversal Card. You cannot request claim reimbursement for any expense purchased with your Beniversal Card.

How the Plan Reimburses You from Your Flexible Spending Accounts
In order to receive reimbursement for eligible medical expenses not purchased with the Beniversal Card, you must submit a completed Benefit Resource claim form accompanied by the required documentation of the expense being claimed. For a medical claim, the documentation can be an itemized statement or bill from your provider or an itemized Explanation of Benefits (EOB) from your insurance carrier. The documentation must clearly indicate the name of the provider, a description of the service provided, the date the service was provided and your out-of-pocket cost for the service after insurance payments have been made. For a dependent care claim, this documentation must clearly indicate the eligible dependent's name, the dates of service, a description of the services provided, your cost for the service and the provider's name. For an adoption assistance claim, this documentation must clearly identify the eligible child, type of adoption, a description of the service provided, the provider's name, the date of service and your cost for the service.

Note that only services provided during the time frame indicated in Section B of your Plan Highlights are eligible for reimbursement. Claims for reimbursement of eligible expenses must be submitted after the service has been provided. The IRS allows one exception: orthodontia expenses are eligible for reimbursement on either the date of payment, date of service, or payment due date on statements/coupons.

If you are enrolled in a Medical FSA, you may be reimbursed up to the full amount of your annual election less the amount of prior reimbursements for the plan year plus any Medical FSA Rollover amounts from the prior plan year. Section B of your Plan Highlights indicates if the plan allows the rollover. If you are enrolled in a Dependent Care FSA or Adoption Assistance FSA, the amount available for reimbursement is limited to the cash balance in your account at that time.

Claims are processed by Benefit Resource per the schedule indicated in Section B of your Plan Highlights. Claims must be received by Benefit Resource within the time frame indicated in Section B of your Plan Highlights. Claims denied during the run-out period may be resubmitted, but must be received within the time frame indicated in Section B of your Plan Highlights.

Qualified Reservists Distributions (QRD)
If you are enrolled in a Medical FSA and are called to or ordered to report to active duty as a reservist for a period of at least 180 days or for an indefinite period, you may be eligible to receive reimbursement of the balance of your unused Medical FSA contribution amount on an after-tax basis. Section B of your Plan Highlights indicates if your employer has elected to permit such distributions.

Health Savings Account (HSA) Contributions
You can elect HSA contributions only if your employer offers the HSA described in the Plan Highlights, if you are covered by an HSA-compatible High Deductible Health Plan, and if you meet the other criteria for HSA participation.

If you have medical insurance that is not an HSA-compatible High Deductible Health Plan, or if you are enrolled in Medicare, you cannot make HSA contributions.

Also, if you participate in a Medical FSA, or are covered under another employer's Medical FSA, such as if your spouse participates in a Medical FSA and your medical expenses are eligible for reimbursement from that account, you cannot make HSA contributions at any time during the Medical FSA coverage period, even if the Medical FSA balance reaches $0. If the Medical FSA has a grace period, then you also cannot elect HSA benefits during the first three calendar months after the close of the Medical FSA plan year unless your account balance in the Medical FSA at the end of the plan year was $0. These restrictions do not apply to a Limited Medical FSA.

Likewise, if you participate in a General Health Reimbursement Account (HRA), or are covered under another employer's General HRA, such as if your spouse participates in a General HRA and your medical expenses are eligible for reimbursement from that account, you cannot make HSA contributions at any time during the General HRA coverage period. If the employer sponsoring the General HRA allows you to waive or suspend participation prior to the start of the new HRA plan year or if your balance at the end of a plan year is $0 and you waive participation for the following plan year, then you may be permitted to make HSA contributions under this plan. These restrictions do not apply to a Limited HRA.

The amount you can contribute to an HSA is limited by tax laws. Your maximum contribution depends in part on your HSA-compatible High Deductible Health coverage option for the calendar year in which the contribution is made. An additional catch-up contribution may be made by participants who are age 55 or older. Your employer may also make a contribution to your HSA. Contributions must be coordinated to ensure the HSA maximum annual contribution limit set by the IRS is not exceeded.

HSA benefits under this plan consist solely of the ability to make contributions to the HSA through payroll deductions on a tax-free basis and any applicable employer contributions. The HSA trustee/custodian, not your employer, establishes and maintains the HSA. The terms and conditions of coverage and benefits are described in the HSA documents published by the trustee/custodian, and are not a part of this plan.

HSA Withdrawals
Withdrawals from your HSA are limited to the account balance. Funds for eligible medical expenses can be accessed by using:
- your Beniversal Card for HSA at qualified merchants. Please be sure to read the separate communication explaining the special rules and requirements that apply to your card.
- the bill payment service to pay a provider directly.
- the online transfer method to reimburse yourself when the HSA is linked to a personal checking or savings account.

Regardless of how funds from your HSA are accessed, you are responsible for maintaining all documentation and receipts to prove that funds from

your HSA were used for eligible medical expenses.

Changes During the Plan Year

In general, once you have enrolled in the plan, you cannot change your elections or withdraw from the plan during that plan year. Your elections for any given plan year, subject to the exceptions below, must be made before the beginning of that plan year. The plan year begins and ends on the dates indicated in Section A of your Plan Highlights. However, you may be permitted to prospectively change an election during a plan year when:

1. one of the following changes in status occurs that affects eligibility for coverage:
   - a change in your employment status, or in the employment status of your spouse or your eligible dependents, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or your eligible dependents to become or cease to be eligible for coverage under this plan or other employer plan providing the same type of benefits. (Note: If your employment terminates and resumes in the same plan year within a period of 30 days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.)
   - a change in your legal marital status (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
   - a change in your place of residence, or the place of residence of your spouse or your eligible dependents.
   - a change in your dependent's eligibility for coverage due to the dependent's age, student status, marital status or similar circumstance.
   - a change in the number of your dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child).
   - any other change that is a "change in status" under Federal law.
2. there is a significant change in the cost of coverage. (If there is an ordinary increase or decrease in premiums, your payroll deductions will be automatically adjusted to reflect the change. Dependent Care FSA elections cannot be changed midyear due to an increase in cost for services provided by a relative.)
3. there is a significant curtailment in or cessation of coverage (provided any curtailment of health insurance coverage must constitute reduced coverage for employees generally).
4. there is an addition or significant improvement of a benefit package option.
5. your spouse, your eligible dependents or former spouse makes a change under another plan which is either (i) a permitted mid-year election change (as described above), or (ii) made during the normal election period for the other plan and that election period is different from the plan year of this plan.
6. you, your spouse or your eligible dependents lose coverage under a group health plan of a governmental or educational institution.
7. you intend to purchase health insurance coverage through a Marketplace (Exchange), as established by the Affordable Care Act (ACA), during the Marketplace's special enrollment period or their annual enrollment period. The new coverage must be effective the day immediately following the last day that your original coverage ended.
8. your hours of service are reduced to average less than 30 hours per week, *but* the reduction does not affect your eligibility under your employer's group health insurance; *however*,
   - you intend to enroll in another health insurance plan that provides minimum essential coverage, *and*
   - the new coverage is effective no later than the first day of the second month following the date the original coverage ended. (e.g. original overage ended 6/15; new coverage must begin no later than 8/1).
9. you exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
10. you, your spouse or your eligible dependents become eligible for continued health coverage under Federal law (COBRA) or similar State law.
11. a court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.
12. you, your spouse or your eligible dependents become entitled to or lose Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).
13. you commence or return from a statutory leave of absence.

In addition, you may only change your election for an Adoption Assistance FSA if you commence or terminate an adoption proceeding.

Whenever any of the events listed above occurs, the election changes permitted are only those that conform to and are consistent with that event. See the Election Change Overview to determine which benefit election changes are permitted under the above circumstances. For example, a Medical FSA election cannot be changed due to an event described in paragraphs 2 through 8 above. A request to change an election due to one of the events listed above must be submitted to your employer within the time frame required by your employer. Note also that participants cannot reduce FSA elections to the point where contributions are less than the amount already reimbursable for that plan year.

You can also prospectively change or revoke your salary reduction elections for Health Savings Account contributions at any time, so long as the election is made by any applicable administrative processing deadline imposed by your employer or Benefit Resource.

The Plan Administrator may, at any time, amend a participant's salary reduction amount for the coverage period in order to maintain compliance with nondiscrimination rules or to maintain the plan's status under Section 125 of the Code.

Loss of Eligibility (including termination of employment)

If you lose eligibility during the plan year, your group health insurance coverage will continue during any period for which premium payments have already been deducted from your pay. In addition, Federal law (COBRA) may give you the right to continue your group health insurance (e.g. medical, dental, vision) coverage at the group rate. If you lose eligibility, you will receive information about your rights to continuation of coverage from your employer.

If you are enrolled in a Medical FSA and lose eligibility during the plan year, you may claim reimbursement of expenses for eligible medical services provided on or before your last day of eligibility. To do so, you must submit your claim for reimbursement within the time frame indicated in Section B of your Plan Highlights.

If your coverage terminates under your Medical FSA because of a COBRA qualifying event (e.g. termination of employment), you will be given the opportunity to continue coverage under the Medical FSA by making after-tax contributions to the plan at the same rate you were making contributions to the plan before the COBRA event, plus a 2% administrative fee. You can only elect such coverage if the remaining contributions you are scheduled to make to your Medical FSA for the plan year (plus 2%) is less than the remaining medical expense reimbursements that you are entitled to receive from the plan. If you elect COBRA coverage for your Medical FSA, the coverage will be available only for the remaining portion of the plan year in which the COBRA qualifying event occurs (e.g. you cannot continue it for the next plan year). You must make special arrangements with your employer to pay the required after-tax contributions to continue your Medical FSA under COBRA. See the COBRA Rights section below for more information.

By contrast, if you are enrolled in a Dependent Care or Adoption Assistance FSA and lose eligibility during the plan year, any funds left in an account are available to pay expenses for eligible services provided at any time during the plan year. You must submit your claim for

reimbursement within the time frame indicated in Section B of your Plan Highlights.

If you are enrolled in an HSA and you lose eligibility, you can still claim benefits from a Health Savings Account in accordance with Section 223 of the Code and the terms and conditions determined by the HSA trustee/custodian. Please note: at the time of termination of employment your account will be administered directly by the trustee/custodian who will contact you directly regarding your account.

Making a Decision
In deciding whether to enroll in the Flexible Benefit Plan, you should remember that you can pick and choose among the different components that are offered under your plan: the tax-free insurance premium feature, the Medical FSA feature, the Dependent Care FSA feature, the Adoption Assistance FSA feature and the Health Savings Account feature. Before you make a decision about whether to participate in a Medical or Dependent Care FSA, please review the Medical Expense Worksheet and Dependent Care Expense Worksheet to determine whether to elect either or both of these features.

Your Responsibilities
To ensure that your benefits are paid correctly and on time, you have certain responsibilities under the plan. You must:
- save all receipts,
- complete claim forms accurately,
- submit eligible claims in a timely manner, and
- submit any other paperwork the Plan Administrator may require.

Other Things You Should Know
The Plan Administrator manages the operation and administration of the plan. The Plan Administrator will answer your questions about the plan and provide you with any forms you need. The Plan Administrator has the discretionary authority to interpret the Plan Document and decide any and all questions arising in the administration, interpretation and application of the plan. The decisions of the Plan Administrator and its actions with respect to the plan shall be conclusive and binding, except to the extent they are subject to judicial review described elsewhere in this document. Section A of your Plan Highlights contains important information about the plan, including the Plan Administrator's name, address and telephone number. Together, the Plan Highlights and this document constitute the SPD.

This SPD summarizes only the major features of the plan. The employer maintains a Plan Document on file which you may review upon request. The Plan Document is more precise than this SPD, so if anything in this description seems to differ from the Plan Document, the Plan Document controls.

Federal law requires Benefit Resource to provide you with the important information contained in the following sections. Please read this information carefully and save this document, along with your Plan Highlights, Medical Expense Worksheet and Dependent Care Expense Worksheet for future reference. The section below regarding your rights under ERISA will inform you about the protection afforded to participants in this plan under Federal law. The terms or provisions of ERISA described in this summary shall apply only to the extent that the statute so requires.

The employer may amend or terminate the plan at any time. In the event that your employer amends or terminates this plan, you will be notified about any changes that will affect your benefits.

The plan will use and/or disclose Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996.

COBRA Rights
COBRA continuation coverage can become available to you when you would otherwise lose your group health plan (e.g. medical, dental, vision, Medical FSA) coverage. The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It can also become available to your spouse or eligible dependents who are covered under the plan when they would otherwise lose their plan coverage.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your eligible dependents could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a participant, you will become a qualified beneficiary if you lose your coverage under the plan because one of the following qualifying events occurs:
- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse or eligible dependent of a participant, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events occurs:
- the participant dies;
- the participant's hours of employment are reduced;
- the participant's employment ends for any reason other than his or her gross misconduct;
- the participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- the participant and spouse become divorced or legally separated; or
- the dependent stops being eligible for coverage under the plan as an eligible dependent.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the participant, or the participant becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. For the other qualifying events (divorce or legal separation of the participant and spouse or a dependent losing eligibility for coverage as an eligible dependent), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Failure to notify the Plan Administrator within 60 days of a qualifying event will result in loss of COBRA rights.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouse and eligible dependents, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of group health insurance coverage. When the qualifying event is the death of the participant, the participant becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a dependent losing eligibility as a dependent, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant becoming entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. In some cases where a COBRA qualified beneficiary experiences a disability or second COBRA qualifying event, an 18-month period of

COBRA continuation coverage can be extended. See the applicable group health insurance plan SPD for more information.

If a participant elects COBRA coverage for Medical FSA, the coverage will be available only for the remaining portion of the plan year in which the COBRA qualifying event occurs (e.g. you cannot continue it for the next plan year). See the Loss of Eligibility section above for more information.

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator.

ERISA Rights

If you elect to participate in the Medical FSA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to that feature of the plan. ERISA provides that all plan participants shall be entitled to do the following:

1. Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents and copies of all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if applicable, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual fiscal report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. Continue group health plan coverage for the participant, spouse or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. The participant, spouse or eligible dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or not addressed in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order, you may file suit in a Federal court (copies of the plan's Qualified Medical Child Support Order procedures are available free of charge and upon request from the Plan Administrator). If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

If you have 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, NW, Washington, DC 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.

Claims and Appeals Procedure

Participants or beneficiaries who disagree with a decision concerning their right to participate or change elections in the plan or to receive reimbursement from a Medical, Dependent Care or Adoption Assistance FSA may file a claim in writing with the Plan Administrator. Claims and/or appeals of denied claims may be made by the participant or the participant's authorized representative (the "Claimant").

All claims and appeals under the plan will be handled in a fair and impartial manner.

Eligibility Claims and Appeals Procedure

If a Claimant is inquiring about or disagrees with a decision concerning the right to participate or make or change elections in the plan (and the claim does not involve a claim for benefits), the following procedures applies. The Claimant may file a claim in writing with the Plan Administrator, who will review the claim and generally will notify the Claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If an eligibility claim is denied in whole or in part, the Plan Administrator will provide the Claimant with written notice within the time period described above, written in an understandable manner, describing: (i) the specific reasons for the denial; (ii) specific reference to the provision of this plan upon which the denial is based; (iii) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (iv) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; and (v) a description of the plan's internal review procedures, information regarding how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review.

Claimants who disagree with the decision reached by the Plan Administrator may submit a written appeal within 60 days of receiving the initial adverse decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access to and copies of all plan documents, records and other information relevant to the claim.

The Plan Administrator will review the appeal and will generally issue a written decision within 60 days of its receipt. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the Claimant will receive notification of the decision. In the case of an adverse decision, the notice

will: (i) explain the reason or reasons for the decision; (ii) include specific references to plan provisions upon which the decision is based; and (iii) indicate that the Claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. The notice will also include a statement describing any voluntary appeal procedures offered by the plan and the Claimant's right to obtain the information about such procedures, a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and a statement of the Claimant's right to bring an action under ERISA.

Benefits Claims and Appeals Procedure

Claims for benefits that are insured are reviewed in accordance with claims and appeals procedures contained in the insurance policies. All other general claims or requests should be directed to the Plan Administrator under the procedure above. Any claim for Medical FSA, Dependent Care FSA or Adoption Assistance FSA benefits is made by submitting a written application to Benefit Resource. Claims for Flexible Spending Account benefits will be paid in accordance with the terms of the plan.

If any part of a claim for Medical FSA benefits is denied, Benefit Resource will provide the Claimant with a written notice, within 30 days after the receipt of the claim, setting forth: (i) the specific reasons for the denial; (ii) sufficient information to identify the claim involved; (iii) specific reference to the provision of this plan upon which the denial is based; (iv) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (v) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; (vi) a description of the plan's review procedures, how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review; (vii) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy will be provided free of charge to the Claimant upon request; (viii) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (ix) the identity of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination. The notice will be written in an understandable manner. If special circumstances require it, Benefit Resource may extend the time for deciding a medical expense claim for up to an additional 15 days by providing written notice of the extension to the Claimant. If the extra time is needed because the Claimant has not provided information needed to decide the claim, the notice will also describe the needed information and the Claimant will have 45 days to provide the needed information. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received.

If any part of a claim for Dependent Care FSA or Adoption Assistance FSA benefits is denied, absent special circumstances requiring an extension of time, Benefit Resource will provide a written notice, within 90 days after the receipt of the claim, setting forth the same items (i) through (vii) above unless extra time is needed to decide the claim. If extra time is needed, the 90-day period may be extended by an additional 90 days (for a total of 180 days), and the Claimant will be notified in writing during the initial 90-day period of the special circumstances requiring an extension and the date by which Benefit Resource expects to render a decision.

If a Claimant would like to appeal a denial of a Medical FSA claim, the Claimant has 180 days after receipt of written notice of denial in which to notify the Plan Administrator in writing. The Plan Administrator will review an appeal for medical expenses and provide a written decision within 60 days. The review will not defer to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual. If a Claimant's medical expense appeal is denied and the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with training and experience in the relevant medical field. This health care professional will not have been involved in the original denial decision, nor be supervised by the health care professional involved in the initial decision. Medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination will be identified in the written appeal response, without regard to whether the advice was relied upon in making the benefit determination.

If a Claimant would like to appeal a denial of a Dependent Care or Adoption Assistance FSA claim, the Claimant must notify the Plan Administrator in writing within 60 days after receipt of written notice of denial. The Plan Administrator will review an appeal for dependent care or adoption expenses and provide a written decision within 60 days, unless extra time is needed to review the claim. If extra time is needed, the 60-day period may be extended by an additional 60 days (for a total of 120 days) and the Claimant will be notified in writing within the initial 60-day period of the special circumstances requiring an extension and the date by which the Plan Administrator expects to render a decision. If extra time is needed because the Claimant has not provided information needed to review the claim, and if the Claimant provides additional information in response to such a request, a decision will be rendered within 60 days of when the information is received.

The Claimant may review any pertinent documents free of charge and submit any written issues and comments to the Plan Administrator. The Claimant may review the plan's claim file and present evidence and testimony in support of the claim.

If during the appeal process the plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently before the deadline for the plan to provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan denies an appeal based on a new or additional rationale, the plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently before the deadline for the plan to provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

The Plan Administrator's written decision will set forth the same elements required for the written notice of claim denial described above. The written decision on appeal will also include a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, a statement of the Claimant's rights to bring a civil action under Section 502(a) of ERISA.

Keep Your Plan Informed of Address Changes

In order to protect the rights of you, your spouse and your eligible dependents, you should keep the Plan Administrator informed of any address changes. You should also keep copies of any notices you send to the Plan Administrator.

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NOTE: The chart below indicates whether an election for a specific coverage may be changed when a particular event occurs. Election changes must conform to and be consistent with the event. (Note that this is just an overview and not a complete explanation of the regulations governing permissible election changes. See the SPD and the Plan Document for additional information.)

Event	Major Medical, Dental, Vision	Medical FSA*	Dependent Care FSA	GTL, AD&D, Disability	Adoption Assistance FSA
1. Change in Status that affects eligibility (six events)	Applies	Applies	Applies	Applies	Applies
2. Cost changes with automatic increases/decreases in elective contributions	Applies	N/A	Applies	Applies	N/A
3. Significant change in cost of coverage	Applies	N/A	Applies	Applies	N/A
4. Significant curtailment of coverage	Applies	N/A	Applies	Applies	N/A
5. Addition or significant improvement of benefit package option	Applies	N/A	Applies	Applies	N/A
6. Change in coverage under other employer cafeteria plan	Applies	N/A	Applies	Applies	N/A
7. Loss of coverage under group health plan of governmental or educational institution	Applies	N/A	N/A	N/A	N/A
8. Changes in 401(k) contributions	N/A	N/A	N/A	N/A	N/A
9. HIPAA special enrollment rights	Applies	Applies	N/A	N/A	N/A
10. COBRA qualifying event	Applies	N/A	N/A	N/A	N/A
11. Judgment, decree or order	Applies	Applies	N/A	N/A	N/A
12. Medicare or Medicaid eligibility	Applies	Applies	N/A	N/A	N/A
13. FMLA leave of absence	Applies	Applies	Applies	Applies	N/A
14. Purchase of health insurance coverage through the Marketplace (Exchange)	Applies to Major Medical only	N/A	N/A	N/A	N/A
15. Reduction in service hours to average 30 hours/week (reduction does not affect your eligibility under your employer's group health plan)	Applies to Major Medical only	N/A	N/A	N/A	N/A
16. Tax-Free HSA Contributions	N/A	N/A	N/A	N/A	N/A

**Medical FSA also includes General Medical and Limited Medical Flexible Spending Accounts.*