FLEX Department

Employee Benefit Specialists
P.O. Box 11657
Pleasanton, CA 94588
P 888.327-2770 F 925.460.3920

Dear Flexible Benefit Plan Participant:

To assist in providing service to you for your flexible spending accounts, within this packet we have information on the following:

- **Claim Form for Medical / Dependent Care Expenses**

  Please submit your claims with receipts online (https://ebsbenefits.lh1ondemand.com), by fax (925.460.3929) or via mail (EBS, P.O. Box 11657, Pleasanton, CA 94588). Should you have any questions on how to file your claim, instructions follow the claim form in this packet. You may also call our Customer Service Center for assistance from 8AM – 5 PM PST, Monday through Friday at 888.327.2770.

- **Direct Deposit Form**

  This form can be used to initiate, change or cancel your direct deposit. This service alleviates the time spent waiting for a check in the mail and is available to all plan participants. Please allow two weeks after receipt by EBS for your direct deposit to be set-up for reimbursement.

- **Dependent Care Bill from Provider Form**

  This form is for those participating in the Dependent Care plan. This form can be used in lieu of multiple receipts from your dependent care provider. For example, you can fill out the form for any amount of time up to the end of the plan year, have your provider sign the form (agreeing to the information you have completed), complete and attach to a claim form and fax or mail it to EBS. If you use this form, you will not need to send in weekly, monthly or quarterly receipts. Should you change care providers during the year, request another form from EBS and ask to replace the one on file. This claim will stay on file and as contributions are received by EBS, payments will be forwarded automatically (either by direct deposit or by a mailed paper check).

- **Flexible Spending Accounts – Most Frequently Asked Questions**
- **Medical FSA Eligible Expenses (over-the-counter medicines and drugs are now ineligible unless accompanied by a prescription or letter of medical necessity from your provider)**
- **Eligible Expenses for Dependent Care Reimbursement**
- **Information Release Document**
- **Creating and Viewing your Account Online**

  Available 24 hours a day, seven days a week. Access to our FSA website allows you to view your account balance, review claims and payment history, download forms, create a claim, etc.

We are committed to providing you with superior service. Should you have any questions or concerns about your FSA benefits, please call EBS Customer Service at 888.327.2770 and a representative will assist you. You may also e-mail us with any questions you may have to custserv@ebsbenefits.com (please do not email documents that contain your social security number). Additionally, to obtain your balance, claims history and payment history, you can login to your account at https://ebsbenefits.lh1ondemand.com. Your user name is the first initial of your first name, full last name and last four of your social. Your initial password is your full social (you will be prompted to change this upon initial logon). A full user guide is located on our website:
http://www.ebsbenefits.com/pdf/ebs_participant_guide_13.pdf

Sincerely,
EBS Flexible Spending Department

CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES

1. **Instructions:** Completed claim forms with receipts should be faxed or mailed to the following address:
EBS, P.O. Box 11657, Pleasanton, CA 94588 Fax: 925.460.3929

You may also file your claim online at https://ebsbenefits.lh1ondemand.com

*Please see the full list of instructions on the following page.

2. **Employer / Employee Information** ○ **New Address? Check the box if the address listed below is new**

Employer Name _____

Employee Name _____ **SSN** _____

Street Address _____

City / State / Zip Code _____ **Daytime Phone** _____

3. **List of Eligible Expenses**
(over-the-counter medicines and drugs are now ineligible unless accompanied by a prescription or letter of medical necessity from your provider)

Family Member	Relationship to Employee	Date of Service	Description of Expenses	Amount Requested
JANE	SPOUSE	1.1.1	PRESCRIPTION	45.00
> Enter the total amount requested for reimbursement and attach receipts before sending				

4. **Employee Authorization**

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my FSA plan and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program and that I am solely responsible for the accuracy of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my FSA plan.

Employee Signature _____ **Date** _____

CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES ~ *INSTRUCTIONS*

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please list each receipt and itemize each expense. Additional pages may be attached. Receipts with a description of service(s) rendered or an Explanation of Benefits from your insurance provider are required for reimbursement. Credit card receipts or cashed checks are not acceptable documentation.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.
- Completed claim forms should be faxed or mailed or uploaded to: https://ebsbenefits.lh1ondemand.com
  EBS, P.O. Box 11657, Pleasanton, CA 94588 Fax: 925.460.3929
- Be sure to include your employer's name on the form.
- Be sure to note if there has been an address change. There is a circle to check on the claim form to indicate that the address listed is new.
- Attach all receipts to the claim form before sending to EBS. Receipts MUST include the following information:
  - Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
  - The date the service was provided or the date the item was purchased;
  - The name of the service provider or the merchant;
  - Description of the service or item purchased;
  - A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase; and
  - The amount/cost of the item or service provided.
- All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.
- Be sure all expenses were incurred during the plan year or period of active plan participation before submitting your claim.
- Verify that your expenses were not previously submitted.
- If your claim is rejected, you will be notified in writing explaining the reason and requesting the necessary information needed to process your claim.

Top two reasons claims are denied

- Cancelled checks and credit card receipts are provided as proof of an incurred expense / purchase and
- The statement from the provider lists only payments made (does not list a description of the services rendered or does not list the dates of the services / purchases).

Per the IRS, receipts are required that show both a description of services / purchases and the date of the services / purchases.

ebs
Employee Benefit Specialists

DIRECT DEPOSIT FORM AUTHORIZATION AGREEMENT

Mail completed forms to Employee Benefit Specialists, Inc., PO Box 11657, Pleasanton, CA 94588 or fax to: 925.460.3929

This form can be used to initiate, change or cancel your direct deposit. This service alleviates the time spent waiting for a check in the mail and is available to all plan participants. Please note – this form must be sent to EBS two weeks before the reimbursement method is changed.

All requests for Direct Deposit must be submitted on this form and include a voided check for the account. Forms without a voided check attached will not be processed. Deposit slips are not acceptable as appropriate routing numbers may not be available.

Reimbursement will only occur if you have submitted a claim to EBS with receipts for eligible expenses. EBS does not guarantee payments into your account on any date. EBS is not responsible for bank charges of any type that you may incur for direct deposit transactions. Do NOT assume that a payment has been made to your account at any time. You are solely responsible for checking with your bank as to the deposit amount and date of direct deposits made to your account. You may use the on-line account balance system (through EBS' website), EBS' automated account balance system by phone or contact EBS Customer Service to check the status of your flexible spending account.

By submitting this form, you understand that your claims reimbursements will be deposited into the listed account.

Please place an x in the appropriate box:

O Initiate Direct Deposit O Change Account O Cancel Direct Deposit

Employer Name: _____

Employee Name: _____ SSN: _____

Employee Address: _____ Daytime Phone: _____

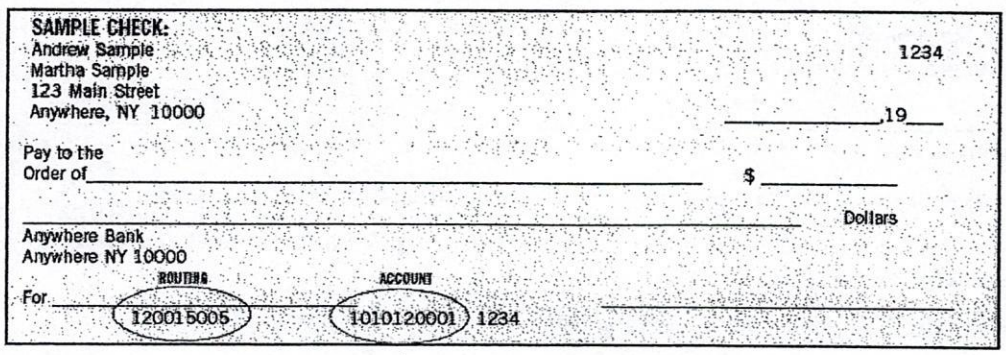
Bank Name & Address: _____

Bank Routing #: _____ Bank Account #: _____

O Checking Account O Savings Account

Authorizing Signature: _____

For assistance in finding routing and account numbers please see below:



Routing Number must be nine digits. If the first two digits are not 01 through 12 or 21 through 32, your direct deposit request will be rejected. **The Account Number** can be up to 17 characters (both numbers and letters) - include hyphens but omit spaces and special symbols.

DEPENDENT CARE BILL FROM PROVIDER FORM

Mail completed forms to Employee Benefit Specialists, Inc., PO Box 11657, Pleasanton, CA 94588 or fax to: 925.460.3929

This form is for those participating in the Dependent Care Account. This form can be used in lieu of multiple receipts from your dependent care provider. For example, you can fill out the form for any amount of time up to the end of the plan year, have your provider sign the form (agreeing to the information you have completed), complete and attach to a claim form and fax or mail it to EBS. If you use this form, you will not need to send in weekly, monthly or quarterly receipts. Should you change care providers during the year, request another form from EBS and ask to replace the one on file. This claim will stay on file and as contributions are received by EBS, payments will be forwarded automatically (either by direct deposit or by a mailed paper check).

This form must be completed in its entirety, signed by your provider and attached to a completed claim form in order to be processed by EBS. If you need Customer Service assistance, representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail EBS Customer Service at custserv@ebsbenefits.com. Please do not email your claim or include any confidential information, such as your Social Security number, in your email for security reasons.

Employer Name _____

Employee _____ **SSN** _____

Street Address _____

City / State / Zip Code _____ **Daytime Phone** _____

Name of the person for whom the services are provided: _____

_____

Cost of Services Provided – amount paid per week / per month / per year – for all dependents listed above:

$ _____ per week $ _____ per month $ _____ per year

Dates of Service:

From _____ / _____ / _____ To _____ / _____ / _____
(example – from 1/1/10 to 12/31/10)

Name of the Person or Organization Providing the Service:

Print Name of Provider _____ **Tax ID or SSN or Provider** _____

Signature of Provider _____ **Date Form Completed** _____

This form only needs to be completed once during the period of service dates provided. If there is any change to the above information a new form must be submitted in its place. A new form must be submitted for any other period not included in the dates of service portion noted above. As a participant in this plan, you are responsible for providing accurate information including the verification of eligible expenses as well as the amounts requested. **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.

FLEXIBLE SPENDING ACCOUNTS ~ MOST FREQUENTLY ASKED QUESTIONS

How do I get reimbursed from this plan?

– You need to send in a claim form (instructions are on page three) and receipts for eligible expenses.

How do I know if my expenses are eligible for reimbursement?

– A partial list of eligible expenses is included in this packet.

What information needs to be included on receipts for reimbursement?

– Attach all receipts to the claim form before sending to EBS. Receipts MUST include the following information:
  - Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
  - The date the service was provided or the date the item was purchased;
  - The name of the service provider or the merchant;
  - Description of the service or item purchased;
  - A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase; and
  - The amount/cost of the item or service provided.

– All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.

Why is a description of service required on my receipts?

– The IRS determines eligible expenses and the documentation required to claim a reimbursement from this plan. A documented description of services or products is required to prove that your incurred expense is eligible for reimbursement under the guidelines set by the IRS for this plan.

Why would EBS deny my claim?

– The most commons reasons claims are denied are:
  - Missing or illegible information;
  - Submission of ineligible expenses;
  - Receipts are lacking a description of service / items purchased;
  - Expenses have been incurred outside the plan year; and
  - Expenses have already been submitted (duplicate claims).

How long does it take EBS to process claims?

– All claims are processed within three to five business days after receipt of complete information. Reimbursements could be timed differently depending on your employer. If you have questions on the timing of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

May I fax my claim to EBS?

– Yes – claims should be faxed to 925.460.3929.

If I fax a claim, do you need originals in the mail?

– No, please keep the original receipts for your records.

What is the deadline for submitting claims?

– Please contact Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770 for submission deadlines for your specific plan.

Why would the reimbursement I received be less than the claim I sent?

- You may have exceeded the amount available to you. Medical FSA reimbursements are limited to your annual election (the amount you elected to set aside at the beginning of the plan year). Reimbursements are paid up to the annual election amount at any time during the plan year but cannot exceed this amount. Dependent Care reimbursements are limited to the amount in your account at the time of your claim.

  For example, if you have made three contributions of $50 each, you would have an account balance of $150. If you sent in a claim for $200, you will receive only the $150 until further contributions are made. As soon as we receive further contributions to the plan, the balance of the claim (in this case $50) will be paid up to the amount in the account, not to exceed your annual election amount for that plan.

- A portion of your claim may have been denied. If so, you will receive a letter in the mail explaining why that portion of your claim was denied. If you have questions on the rejection of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

What if I need to change my annual elections?

- You may only change your annual elections during the plan year if you qualify for a "change in family status". To qualify, you must experience a life-changing event such as marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in spouse's employment, etc. These changes are defined by the IRS and outlined in your plan communication materials. If you have a question about your status, you should consult your employer.

Are my spouse and I both able to elect $5,000 as our Dependent Care annual election?

- If you are married and file a joint tax return, the maximum amount you may elect is $5,000. The maximum amount available if you are married but filing separate returns is $2,650 If you file separately, you cannot claim the same expense in each of your dependent care accounts.

What happens if I don't claim all the money in my account?

- According to the IRS guidelines, funds that are not claimed during the plan year are forfeited to the plan. This is called the "use it or lose it" clause. Funds are not transferable from one plan year to another and they are not available for other benefits. The unused funds are retained by your plan sponsor and are often used to offset administrative costs of the plan.

What information does EBS report to the IRS?

- EBS does not supply information to the IRS related to your FSA. Your plan sponsor may be required to file an IRS form 5500 which includes participation and total disbursement information (does not include individual FSA account information) and your participation in the Dependent Care Assistance program will be reported on your W2 at the end of the year by your employer.

Tips for a successful claim submission

- Verify all expenses were incurred during the plan year before submitting;
- Verify the expenses were not previously submitted;
- Make sure that all of the information provided on the claim form is clearly legible – claim forms that cannot be read will not be processed;
- Make sure each receipt and each expense / purchase is itemized; and
- Make sure all expenses / purchases have a description on the receipt or Explanation of Benefits.

How can I find out what my account balance is or when EBS sent me a claim reimbursement?

- You are able to logon through the Member Center at www.ebsbenefits.com for online account balance information and information on claims paid.
- EBS representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail EBS Customer Service at custserv@ebsbenefits.com. Please do not include any confidential information, such as your Social Security number, in your email for security reasons.

ELIGIBLE MEDICAL EXPENSES – post 12/31/2010

The IRS has established a list of medical, dental and vision care expenses that are eligible for reimbursement under this plan. You may request reimbursement for eligible expenses for yourself, your spouse or your dependents. If you incur an expense that is not listed here and you would like to know whether or not it is an eligible expense under this plan, please contact EBS Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770. You may also refer to IRS Publication 502 "Medical and Dental Expenses." You can order this publication by calling the IRS at 800-829-3676.

Eligible Medical Care Expenses (partial list)

- Acupuncture
- Ambulance
- Artificial Limbs
- Chiropractors' fees
- Coinsurance
- Contraceptive prescriptions
- Co-payments
- Crutches
- Diabetic supplies
- Gynecologists' fees
- Health insurance deductibles
- Hearing aids / batteries
- Hypnosis for medical reasons
- Immunizations / vaccinations
- Insulin
- Mileage / travel costs related to an eligible expense
- Laboratory fees
- Orthodontia
- Orthopedic shoes
- Physical therapy fees
- Prescription drugs
- Psychiatrists' / Psychologists' fees
- Psychotherapists' fees
- Routine physicals
- Seeing-eye dog
- Skilled nurses' fees
- Speech therapists' fees
- Smoking cessation treatments & prescriptions
- Sterilization fees
- Treatment for substance addiction
- Wheelchairs
- Weight loss treatments (prescribed by a physician)

Eligible Dental Care Expenses (partial list)

- Dentists' fees (other than for cosmetic services)
- Dentures
- Orthodontia
- Periodontist fees

Eligible Vision Care Expenses (partial list)

- Eye exams
- Laser / Lasik eye surgery
- Prescription eyeglasses and / or contact lenses
- Radial keratotomy / ortho keratology

Ineligible Expenses

This partial list includes medical, dental or vision expenses that are considered not eligible for reimbursement from your Medical Care Reimbursement Account:

- Cosmetic surgery or procedures of any kind
- Health club memberships
- Insurance premiums
- Lens replacement insurance
- Marriage counseling
- Over-the-counter drug and medicine expenses without a prescription or letter of medical necessity (includes items such as acid controllers, allergy & sinus medicines, antibiotic products, anti-gas, anti-itch & insect bites, baby rash ointments/creams, cold sore remedies, cough, cold & flu medicines, laxatives, pain relief & sleep aids)
- Physical therapy for general well-being
- Supplements prescribed by an alternative provider (i.e. acupuncturist)
- Union dues

ELIGIBLE DEPENDENT CARE EXPENSES

A Dependent Care Reimbursement Account allows you to set aside part of your salary each pay period on a pre-tax basis to reimburse eligible expenses incurred for the care of your child, disabled spouse, elderly parent or other dependent who is physically or mentally incapable of self-care, so that you (and your spouse, if applicable) can work.

Eligible Dependents

- Your child age 12 or younger of whom you have custody and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with custody (rights to claim the child for tax purposes) can consider the child an eligible dependent under this plan.
- Your child of any age who is physically or mentally unable to care for him/herself, even if he/she does not entitle you to a deduction on your federal tax return.
- Your spouse who is physically or mentally unable to care for him/herself, even if he/she does not entitle you to a deduction on your federal tax return.

Guidelines for Eligible Dependent Care Expenses

- Only care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under age 19 would be eligible.
- If your dependent is in first grade or higher (through age 12), the cost of schooling must be separated from the cost of care submitted for reimbursement.
- If your dependent is in a grade before first grade and the cost of care and the cost of schooling can be separated, then only the cost of care is reimbursable. However, if the cost of schooling cannot be separated from the cost of care, the total cost is reimbursable.
- A dependent care center or child care center would be eligible for reimbursement (if the center cares for more than six children, it must comply with all applicable state and local regulations).
- A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent would be eligible for reimbursement.
- To qualify for reimbursement, you must provide your dependent care provider's tax ID number or social security number on your federal tax return (IRS form 2441). If you fail to provide this information, your reimbursements may not be eligible and may be reclassified as taxable income by the IRS.
- You are responsible for making sure that the expenses you submit for reimbursement are considered eligible expenses by the IRS. If you are not sure whether an expense is eligible, please contact EBS Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770. You may also refer to IRS Publication 503: Child and Dependent Care Expenses which is available by calling the IRS at 800-829-3676 or through the IRS website in the Forms and Publications section.
- If you are married and file a joint tax return, the maximum amount you may elect is $5,000. The maximum amount available if you are married but filing separate returns is $2,650 If you file separately, you cannot claim the same expense in each of your dependent care accounts.

INFORMATION RELEASE DOCUMENT

Legislation has been enacted to protect confidential or personal information for much of the benefit information that EBS stores to administer your benefit plan. That protected information cannot be released to a spouse, or other person, without authorization from you, as the plan participant. If you would like to have EBS release your account balance, or relative information about the benefit in which you are participating, please complete this form in its entirety and return to EBS.

What is PHI? Protected health information (PHI) is individually identifiable information, which is created, modified, received or maintained by a covered entity that relates to an individual's past, present or future physical or mental condition, treatment, or payment for care. It includes a person's name or information that taken together could be used to identify a person, such as:

- Date of birth
- Medical records number
- Address, zip code
- License numbers
- Social Security number
- Gender
- Health plan beneficiary numbers
- Phone number, email, fax number, IP address
- Full face photographic images

This form is: O NEW O REPRESENTS A CHANGE O TERMINATION

Your Name: _____ SSN: _____

Name of Your Employer: _____

Name of person(s) in which you authorize EBS to release information and their relationship to you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Benefit Plan(s) for which you authorize release of information:

_____ Flexible Spending Accounts – Medical & Dependent Care

_____ Commuter – Transit & Parking

_____ COBRA

_____ Retiree Benefits

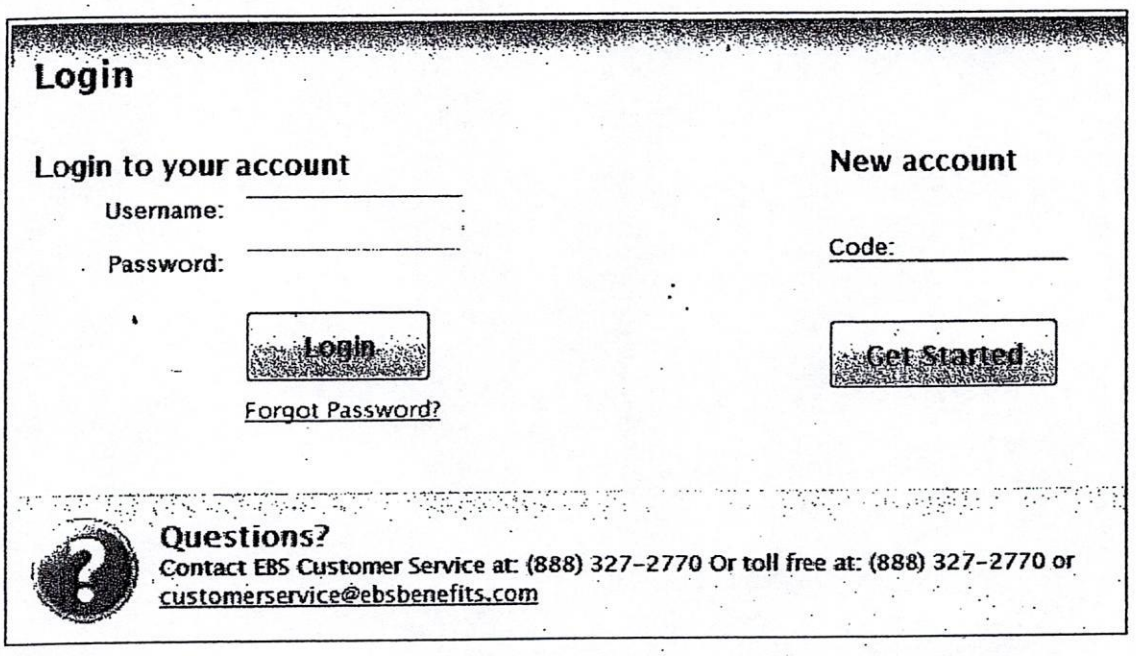
_____ Voluntary Benefits

I agree that EBS may release information as requested by those I have named as authorized above, until this authorization is terminated for revoked by me in writing. I understand that the information my authorized representative may receive may included Medical or other personal information as stored in EBS' database for the benefit(s) in which I am participating.

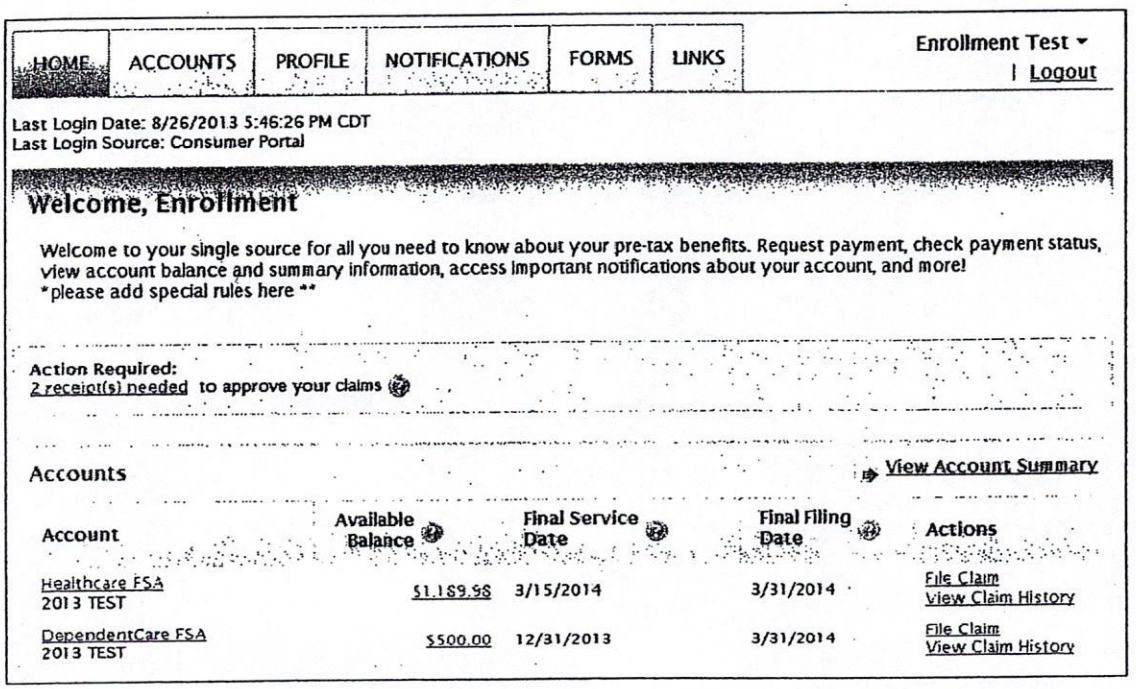
Employee Signature _____ **Date** _____

ONLINE ACCESS TO YOUR ACCOUNT

To access your account online, go to https://ebsbenefits.lh1ondemand.com. Your user name is the first initial of your first name, full last name and last four of your social. Your initial password is your full social (you will be prompted to change this upon initial logon). A full user guide is located on our website: http://www.ebsbenefits.com/pdf/ebs_participant_guide_13.pdf



Once you have created your account and select continue, your plan information will appear on the screen.



Should you have any questions, EBS representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail EBS Customer Service at custserv@ebsbenefits.com. Please do not include any confidential information, such as your Social Security number, in your email for security reasons.

CAFETERIA PLAN

FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY

COUNTY OF TEHAMA

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Section 125 Cafeteria Plan

Part 1. Introduction

Your employer ("Employer") is pleased to sponsor an employee benefit program known as a Cafeteria Plan ("Plan") for certain eligible employees of the Employer. It is called a Cafeteria Plan because you can choose from a selection of different fringe benefit programs according to your needs. Your Employer gives you this opportunity to use a salary conversion arrangement through which you can use pre-tax dollars to pay for your benefits instead of paying for the benefits through after-tax payroll deductions. By paying for the benefits with pre-tax dollars, you save money by not having to pay social security and income taxes on your salary reduction. However, you may still have the option of paying for your benefits with aftertax dollars.

This Summary Plan Description ("SPD") describes the basic features of the Plan; how it operates, and how you can get the maximum advantage from it. The Plan is established pursuant to a plan document into which this SPD is incorporated (i.e. the plan document and this SPD constitute the plan document). However, if a conflict exists between the plan document and this SPD, the plan document will control.

Part 2. General Information about the Plan

Q-1 What is the purpose of the plan?

This Plan is designed to allow eligible employees to choose one or more of the benefits offered through the Plan and, using funds provided through employee salary reduction, to pay for the selected benefits with pre-tax dollars. It is established for the exclusive benefit of Participants.

Q-2 What benefits are offered through the Plan?

The Plan can offer one or more of the following types of benefits ("Benefit Package Options").

- Pre-tax contributions for qualified benefits ("Benefit Package Options") offered under the Plan (as set forth in Part 6 below), which includes a Health FSA and/or Dependent Care FSA

You will receive information materials before each enrollment period explaining the various benefit options your Employer is offering for the next Plan Year.

Q-3 Who can participate in the Plan?

Any employee (as that term is defined in the Plan Document) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan Information Summary (as summarized in Part 6 below), is eligible to participate in this Plan.. [The employer may have separate election requirements for the cafeteria plan, e.g. the employer may require a salary reduction agreement in addition to the health insurance application]

You will cease to be a Participant if (1) the Plan terminates, (2) You cease to be eligible for the Plan (e.g. the Participant's employment is terminated), (3) You revoke your election to participate, or (4) the Plan is amended to exclude you or the class of employees of which you are a member. You may be entitled to temporarily continue coverage under one or more of the Benefit Package Options that provide group health coverage. Refer to the applicable plan summaries for more information on COBRA continuation coverage.

Q-4 What happens if I terminate employment (or cease be eligible) and then I am rehired (become eligible again) during the same Plan Year?

If you terminate your employment or you cease to be eligible for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then you are rehired or again become eligible within 30 days or less of the date of a termination of employment or cessation of eligibility, then you will be reinstated in the Plan (assuming you otherwise satisfy the eligibility requirements of the Plan) with the same elections you had before termination (subject to any restrictions imposed under the applicable Benefit Package Options). If you are rehired or again become eligible more than 30 days following termination of employment or cessation of eligibility and you are otherwise eligible to participate in the Plan, then you may make new elections.

Q-5 What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Part 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Part 2.Q-11 below will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-6 What tax advantages can I gain by participating in the Plan?

By participating in the Plan, you will not have to pay income tax or Social Security tax on your elections. Following is an illustration of how a hypothetical employee saved on taxes by participating in a cafeteria plan. Let's assume our hypothetical employee makes $2,500 each month and has 28% withheld for federal withholding and 7.65% for Social Security. The employee's take-home pay before participating in the Plan is $1,609 a month. Out of that, $348 a month is paid for insurance benefits, $100 for Health FSA, and $200 for Dependent Care FSA. The employee decides to participate in the cafeteria plan. By participating in the Plan and paying contributions on a pre-tax basis under the Plan, the employee saved $230 a month. Following is a table to better illustrate the example.

BREAKDOWN OF PAY CHECK AND DEDUCTIONS	NOT PARTICIPATING IN CAFETERIA PLAN	PARTICIPATING IN CAFETERIA PLAN
Gross Monthly Pay	**$2,500.00**	**$2,500.00**
Less Premium for Major Medical		(348.00)
Less Medical/Dental Expenses		(100.00)
Less Day Care Expenses		(200.00)
Taxable Income	**2,500.00**	**1,852.00**
Less 28% Federal Withholding	(700.00)	(519.00)
Less 7.65% Social Security Tax	(191.00)	(142.00)
Less Premium for Major Medical	(348.00)	
Less Health FSA Expenses	(100.00)	
Less Day Care Expenses	(200.00)	
Spendable Income	**$961.00**	**$1,191.00**

The employee saved $230 a month or $2,760 a year by participating in Plan!

This savings results in extra spendable income and this occurs because the employee participated in the Plan and made the required employee contributions *before* the taxes were withheld. This is just one example of the possible tax savings under the Plan.

Q-7 How do I become a Participant?

You become a Participant by completing and submitting a Benefit Election Form (or Salary Reduction Agreement) to the Plan Administrator (or its designee identified on the election form) during one of the applicable enrollment periods described in Q-8 below. Your effective date of participation is also described in Q-8 below. Coverage under the Benefit Package Options that you elect will begin only as set forth in the summary plan descriptions (or other written material) for each Benefit Package Option that you elect.

Q-8 What are the enrollment periods?

There are three enrollment periods:

1. *Enrollment Period* prior to the Effective Date. This is the enrollment period that occurs before the Plan's Effective Date (as described in the Adoption Agreement). An Election made during this Enrollment Period is effective on the Effective Date of the Plan.

2. *Initial Enrollment Period.* The Initial Enrollment Period is the period during which newly eligible employees enroll in the Plan. The Initial Enrollment Period is described in the enrollment material provided by the Plan Administrator. An election to participate that is made during this enrollment period will be effective on the Plan Entry Date.

3. *Annual Enrollment Period.* The Annual Enrollment Period is the period each year in which participants may elect to change and/or continue their elections or eligible employees may elect to participate for the next Plan Year. The Annual

Enrollment Period is described in your enrollment material that you will receive prior to the Annual Enrollment Period. An election to participate made during this period will be effective on the anniversary date.

If you have the ability to enroll by phone or Internet, separate enrollment periods may be set for paper, telephone, and Internet. Your Employer will tell you what enrollment periods are established for each.

See Q-10 below for what happens when you fail to return a Benefit Election Form during the enrollment period.

Q-9 How long is my election to participate (or not to participate) effective?

Your elections (either to participate or not) are for the entire Plan Year, which is usually 12 months. The first Plan Year and the last Plan Year may be for a shorter period. See Part 6 below for the exact dates of your Plan Year.

Q-10 What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and you fail to return a Benefit Election Form before the end of the applicable Enrollment Period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to become a Participant until the next Annual Enrollment Period or following the date you experience a change in status that allows you to enroll mid Plan Year (assuming you timely change your election). If you are currently participating in the Plan and fail to submit a Benefit Election Form by the end of the Annual Enrollment Period for the next Plan Year, your elections for the next Plan Year will depend on which benefits you currently have.

1. If you have currently elected to participate in a Health FSA, it will be assumed that you do not want to continue participation in the Health FSA for the next Plan Year.
2. If you have currently elected to participate in a Dependent Care Assistance Plan (DCAP), it will be assumed that you do not want to continue participation in the DCAP for the next Plan Year.

Q-11 Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the benefits you have selected during the Plan Year, although your election will terminate if you are no longer working for the Employer or you are no longer eligible. You may change your elections only during the Annual Enrollment Period, and then the change will not be effective until the beginning of the next Plan Year.

There are several important exceptions to this general rule. You may change or revoke your previous elections during the Plan Year if you experience one of the events listed below:

> **Please refer to the Change of Status Matrix (distributed with this SPD) for a table of the qualifying events, the benefits affected by each event, and the possible changes in elections that may take place for each benefit. If you have a qualifying event, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.**

1. **Changes in Status.** If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:
   - Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
   - Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
   - Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring

a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,

- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student), or
- Change in your, your Spouse's, or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefitunder the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For Health FSA benefits, a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel coverage for the affected Spouse or Dependent.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Dependent Care FSA Benefits.* With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment

must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption.

3. **Certain Judgments, Decrees, and Orders.** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

Q-12 What happens if a claim for benefits under the Plan is denied?

If you are denied a benefit under this Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a benefit under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. The Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision, and you wish to appeal, you must file a written appeal in accordance with the Notice referenced in Step 1 no later than 180 days of receipt of that Notice. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial following appeal.* If the claim is again denied, you will be notified in writing. . If there is only one level of appeal, notice of the denial will be sent no later than 60 days after the appeal is received. See below for more information if the Plan has established two levels of appeal.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial.

Step 6 *(if there is a second level of appeal as indicated in the notice of denial referenced in Step One and/or Four above*): If you still disagree with the decision, and you wish to appeal, you must file a second level appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider (referenced in Step 4). You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Q-13 What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, here could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Part 3. Health FSA Benefits

Participation in the Medical Reimbursement Plan (Health FSA), if listed as a benefit offered under the Plan (see Part 6 below), allows you to purchase a specific level of Health FSA benefits, paying for coverage with pre-tax dollars elected on the Benefit Election Form in lieu of a corresponding amount of current pay. This arrangement helps you because the level of coverage you elect is nontaxable, and you save social security and income taxes on the amount of premiums you pay.

Q-1 Who can participate in the Health FSA?

Any employee (as that term is defined in the Plan Document) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan Information Summary (as summarized in Part 6 below), is eligible to participate in this Plan..

Q-2 How do I become a Participant?

You can participate by electing the Health FSA during the applicable Enrollment Periods described in Part 2.Q-8. See Part 2.Q-8 to determine when your participation will begin. Effective date of participation will vary by Enrollment Period. Once you elect benefits under a Health FSA, a Health Care Account will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Once you become a participant, you may receive reimbursements for Eligible Medical Expenses incurred by you and your Eligible Dependents (see Part 3.Q-10 below for more information on Eligible Dependents.)

Q-3 When does coverage under the Health FSA end?

You continue to participate in the Health FSA until i) you elect not to participate; ii) the end of the Plan Year unless you make an election during the annual election period iii) you no longer satisfy the eligibility requirements described in Part 6 below; (iv) you terminate employment with the employer; or (v) the Plan is terminated or it is amended to exclude you or the class of employees of which you are a member. You may be entitled to temporarily continue your coverage under the Health FSA once your coverage ends for certain reasons. See Q-14 below for more information.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2.Q-5 above apply. However, if your Health FSA coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the Health FSA, at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at Health FSA level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-5 What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to participate until the next Annual Enrollment Period or you experience a change in status event that permits you to enroll in the Plan during the Plan Year. .

If you have currently elected to participate in a Health FSA, it will be assumed that you do not want to continue participation in the Health FSA and the deductions will cease as of the first day of the next Plan Year (unless you elect to stop participating before then).

See Part 2.Q-10 above for further discussion.

Q-6 How do I pay for Health FSA reimbursements?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay and credited to your Health Care Account each pay period. This money will be available for reimbursement of eligible medical expenses. The available amount in your Health Care Account at any particular time will be the total amount elected for the Plan Year under your Health FSA less any reimbursements you may have already received. For example, if you have elected an annual salary conversion of $2,400 for eligible Health FSA benefits, then $2,400 would be credited to your Health FSA Account during the Plan Year. If you are paid semi-monthly, $100 a payday or $200 a month

would be credited to the Health FSA Account to pay for these expenses, but your reimbursements would not depend on the amount you have paid in. You can file for all or part of this $2,400 reimbursement at any time during the Plan Year.

Q-7 What annual benefits are available under the Health FSA, and how much will they cost?

You can choose any amount of annual benefits you desire within the limits set forth in Part 6 below. You will be required to make annual contributions corresponding to your chosen benefit level.

Q-8 How do I receive Reimbursement under the Health FSA?

Under this Health FSA, you can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). The following is a summary of how reimbursement under the traditional paper claims works. *Traditional Paper Claims*: When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g. a receipt, EOB, etc) associated with each expense that indicates the following:

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

b) The date the expense was incurred.

c) The amount of the expense.

You will be reimbursed for your eligible expenses according to the schedule in your enrollment material for the amount available for reimbursement. Remember, the amount you are reimbursed during the Plan Year cannot exceed the annual benefit amount you elected. Also, no check will be written if the current amount payable to the Participant for claims is less than the Minimum Check Amount as specified in Part 6 below. The Minimum Check Amount will not apply when processing claims submitted during the last month of the Plan year or during the closing period.

At the end of the Plan Year, you will have a closing period (as stated in Part 6 below) to turn in claims for expenses incurred during the Plan Year. No claims can be submitted for reimbursement after the closing period ends. Your Employer may set a different closing period, called a "claims submission grace period" for employees terminating during the Plan Year; if so, you will find this information in Part 6 below.

Please read and follow your Claims Filing Instructions carefully to ensure the prompt processing of your claims. Please note that you can submit a claim for more than what you have paid in to date. The reimbursement will be made so long as (1) the claim is equal to or less than the annual elected amount less any previous reimbursements; and (2) the claim is not paid for or has not been reimbursed from any other source.

Q-9 What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

a) The expense is for "medical care" as defined by Code Section 213(d);

b) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products & devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

a) Health insurance premiums; and

b) Expenses incurred for qualified long term care services.

c) Any other expenses that are specifically excluded by the Employer per a list attached and incorporated into the SPD by the Employer

Q-10 Who is an "eligible dependent" for which I can claim expenses for reimbursement?

You can claim reimbursement for eligible medical expenses incurred by your legal spouse (as determined in accordance with state law to the extent consistent with the federal Defense of Marriage Act), any individual who would qualify as a tax dependent of yours under Code Part 152, and any child for whom you are required to provide health coverage pursuant to a Qualified Medical Support Order. Also, children of divorced parents are considered to be a dependent of both parents to the extent that both parents together provide over half of the child's support.

Q-11 When must a reimbursable expense be incurred?

Eligible expenses reimbursed under the Plan must be incurred during the Participant's period of coverage under the Plan. Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for the services or pays for the medical care. During your current participation year, you cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Salary Reduction and Election Form becomes effective, expenses incurred after the date that you stop being eligible under this Health FSA (except as described in Q-14 below) or for any expense incurred after the close of the Plan Year.

Q-12 Can I change the election during the year?

Only if you experience one of the qualifying events listed in Part 2.Q-11 above and follow the procedures outlined within that section.

Q-13 What happens if I still have a balance in my Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any un-cashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

Q-14 Can I continue coverage in my Account?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health FSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

If you are a participant in the Health FSA, then you have a right to choose continuation coverage under the Health FSA if you lose your coverage because of:

- a reduction in your hours of employment;
- a voluntary or involuntary termination of your employment (for reasons otherthan gross misconduct), or
- a military leave of absence that lasts 31 days or longer (in accordance with USERRA).

If you are the spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- the death of your spouse;
- a voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- the divorce or legal separation from your spouse;

In the case of a Dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- the death of the employee;
- a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- his or her parents' divorce or legal separation; or
- he or she ceases to be a dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries"

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

You or your covered dependents (including your spouse) must notify the employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator (or its COBRA Administrator identified in the Plan Information Appendix) is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

The COBRA Participant and/or covered dependent are responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Non-elective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;
- The date that you first become entitled to Medicare, after you elect continuation coverage; or

- The date the employer no longer provides group health coverage to any of its employees

Q-15 What happens if a claim for benefits under the Health FSA is denied?

If you are denied a benefit under the Health FSA, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Service Provider must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the allotted number of days set forth in the notice of denial from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior determination will not be involved in a subsequent decision);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-16 Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. HIPAA Security Rule means the Security Standards published on February 20, 2003 at 45 C.F.R. Parts 160, 162, and 164 as hereafter amended, and Electronic Protected Health Information (ePHI) means electronic protected health information as defined in the HIPAA Security Rule that is created, received, maintained, or transmitted by or on behalf of the plan.

With regard to its use and/or disclosure of ePHI, beginning no later than the compliance date applicable to the plan under the HIPAA Security Rule, April 20, 2005, the Plan Sponsor will:

- Reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the grouphealth plan;
- Ensure that the adequate separation required by Sec. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the group health plan any security incident of which it becomes aware.

Part 4. Dependent Care Assistance Benefit

Another important component of your Employer's Cafeteria Plan is the Dependent Care Assistance Plan. Participation in this Plan allows you to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under a related Dependent Care Assistance Plan (DCAP). A DCAP allows you to provide a source of pre-tax funds to reimburse you for your eligible expenses. You do this by entering into a salary conversion agreement (Benefit Election Form) with the Employer instead of receiving a corresponding amount of your regular pay. This arrangement saves you money; you pay less social security and income taxes because the salary conversion paying for your elected benefits is not taxable.

Q-1 Who can participate in a DCAP?

If you are eligible to be a participant in the Cafeteria Plan, you can participate in the DCAP. If you are married, your spouse must also work, go to school full time, or be incapable of selfcare for you to be eligible.

Q-2 How do I become a Participant?

You can participate by electing the DCAP Benefit during the applicable Enrollment Periods. See Part 2.Q-8 above for your effective date of participation. Effective dates of participation vary by Enrollment Period. Once you elect benefits under this DCAP, a Dependent Care Expense Reimbursement Account (DCAP Account) will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year.

Q-3 When does coverage under the DCAP end?

You continue to participate in the Dependent Care FSA until (i) you elect not to participate; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) the end of the Plan Year unless you make an election to participate during the annual election period; (iv) you terminate employment with the employer (there are special rules for terminating employees), or (v) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. However, you may be able to continue to submit claims for reimbursements for Eligible Employment Related Expenses incurred after the date that you terminate employment up to balance in your Dependent Care Account as of the date you terminate employment.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2.Q-5 above of this SPD apply to the Dependent Care FSA.

Q-5 What happens if I fail to return my Benefit Election form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot become a Participant until the next Plan Year. The only exception to this is if you have experienced one of the qualifying events listed in Q-11 under Part 2 above. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you have currently elected to participate in a DCAP and you fail to return the Benefit Election Form, it will be assumed that you do not want to continue participation in the DCAP and the deductions will cease.

See Q-10 under Part 2 above for further discussion.

Q-6 How are my DCAP reimbursements paid?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay and credited to your DCAP Account each pay period. This money will be available for reimbursement of your dependent care expenses. The available amount in your DCAP Account at any particular time will be the amount credited to your DCAP Account to date less any reimbursements you may have already received.

Q-7 Are there any other limits on what DCAP benefits are tax free?

In addition to the dollar limitations in Part 6 below, the maximum amount of DCAP benefits you may exclude from income during any calendar year cannot be more than:

- If you are **not** married as of the end of the year, your earned income for the year, or
- If you **are** married at the end of the year, the **lesser** of your earned income for the year, or your spouse's earned income.

Q-8 Is there any other way I can save taxes on my DCAP expenses?

Yes, you can claim the Household and Dependent Care Credit when filing your federal income tax return.

Q-9 What is the Household and Dependent Care Credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1050 for one Qualifying Individual or $2100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1152, because the entire expense would have been taken into account, not just the first $3,000.

Q-10 If I participate in the DCAP, can I claim the Household and Dependent Care Credit on my federal income tax return?

If you participate in both, each dollar that you receive under the DCAP FSA reduces the amount of expenses that may be taken into consideration under the Household and Dependent Care Credit (that is, the $3,000 and $6,000 amount).

Example: If you had $5,000 in dependent care expenses for 2001 for two children, but only elected $2000 for your DCAP, you would still be eligible for a partial tax credit. You would calculate your tax credit by subtracting $2,000 (amount reimbursed by DCAP) from $6000 (the maximum allowed for the Household and Dependent Care Credit). This would leave you with $4000, your basis for the Household and Dependent Care Credit. You would then apply the formula for the credit as stated in Q-9 above.

Example: If you had $10,000 in dependent care expenses for 2001 and claimed the maximum $5,000 under a DCAP, you cannot claim the other $5,000 as a Household and Dependent Care Credit on your federal income tax return.

Q-11 Under what circumstances can I receive reimbursement under the DCAP"?

You can be reimbursed for work-related dependent care expenses provided all the following conditions are satisfied:

1. The expenses are for services rendered after the date of your Dependent Care election and before the end of the Plan Year.
2. The individual for whom you incurred the expenses is a "Qualifying Individual". A "Qualifying Individual" is a:
   - Child under age 13 for whom you are entitled to a personal tax exemption as a dependent (or if you are divorced, a child who resides with you without regard to whether you are entitled to the exemption), or
   - Spouse or other tax dependent that is physically or mentally incapable of personal care.
3. The expenses are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household for a Dependent who is age 13 or older, that Dependent must spend at least 8 hours a day in your home.
5. If the incurred expenses are for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and federal laws.
6. The expenses cannot be paid or payable to a child of yours who is under age 19 at the end of the year when the services were rendered or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. This reimbursement (plus all other Dependent Care reimbursements during the same year) may not exceed the least of the following limits:
   - $5,000,
   - $2,500 if you are married, but you and your Spouse file separate tax returns,
   - Your taxable compensation (after your salary reduction under the Plan), or
   - If you are married, your Spouse's actual or deemed earned income.

Your Spouse will be deemed to have earned income of $250 (for one Eligible Dependent) or $500 (for two Eligible Dependents) for each month the Spouse is either (1) physically or mentally incapable of personal care or (2) a full-time student. Your spouse is considered to be a full-time student if the spouse is deemed a full-time student by the "educational institution" attended by the spouse during each of five calendar months during a Plan Year. An educational institution is any educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of student in attendance at the place where its educational activities are regularly carried on.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your federal Income Tax" for further information or clarification.

Q-12 How do I receive my benefits under the DCAP?

Under this DCAP, you can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). The following is a summary of how traditional paper claims reimbursement works. *Traditional Paper Claims*: When you incur an Eligible Employment Related Expense, you file a claim with the Plan Service Provider by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Service Provider. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g. a receipt or invoice) associated with each expense that indicates the following:

a) The date the expense was incurred

b) The amount of the expense.

c) Tax Identification or Social Security Number of Service Provider

The amount of your reimbursement will depend on your current Account Balance (deductions to date minus any previous reimbursements). If your Account Balance is equal to or exceeds your claim, your claim for eligible expenses will be reimbursed in full. If your claim exceeds your current Account balance, the excess part of the claim will be carried over into the following pay cycles to be paid as your balance can cover it. In other words, as additional salary conversion amounts are credited to your Account raising your Account Balance, a reimbursement check will be processed automatically for any unpaid portions of any properly submitted claims. Remember, no expenses can be reimbursed that exceed the payments you have made up to that date minus any previous reimbursements.

You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Benefit Election Form becomes effective, or after the end of the Plan Year. You may be able to submit claims for reimbursement of an eligible expense incurred after the date that you terminate or cease to be eligible for this Plan up to your account balance on the date that you stopped being eligible. Also, no check will be written if the current amount payable to the Participant for claims is less than the Minimum Check Amount as specified in Part 6 below. The Minimum Check Amount will not apply for processing the final checks during any Plan Year.

At the end of the Plan Year, you will have a closing period (as stated in Part 6 below) to turn in claims for expenses incurred during the Plan Year. No claims can be submitted for reimbursement after the closing period ends. Your Employer may set a claims submission grace period for terminated employees; if so, you will find this information in Part 8 below.

Q-13 Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits up to the limits set out in Q-7 and Q-11 above. However, before you can qualify for tax-free treatment, you are required to list the names and taxpayer identification numbers of any persons providing your dependent care services during the calendar year for which you have claimed a tax-free reimbursement. (Be sure to fill out all the spaces on your claim!)

Q-14 Can I change my election if I change day care providers during the year and the rates are different?

Yes, this will be considered a Change of Coverage (see Part 2.Q-11 above). You will need to submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to change the day care provider and the rates.

Q-15 Can I change my election if a relative starts keeping my children for free?

Yes, this will also qualify for the Change of Coverage discussed above. You would submit a Change of Status Form changing providers with the rate being changed to zero. NOTE: You will not be able to change your election as a result of a cost increase or decrease imposed by a relative.

Q-16 What happens if I still have a balance in my DCAP Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year cannot be carried over into the next year, but will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any un-cashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

Q-17 What happens if my claim for DCAP benefits is denied?

If you are denied a claim reimbursement under the Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a claim under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option.

Step 1: Notice is received from Plan Service Provider. If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after reeeipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information isnecessary, and your time limit for submitting the information;

- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6 *(if there is a second level of appeal as indicated in the notice of denial): If you still disagree with the Plan Service Provider's decision, file a second level appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support yourclaim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Part 5. ERISA Rights

This Plan is not a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). However, certain component benefits (such as the Health FSA Plan) may be governed by ERISA. ERISA provides that you, as a Plan Participant, willbe entitled to:

1. **Receive Information about Your Plan and Benefits**

   - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
   - Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, 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.

2. **Continue Group Health Plan Coverage**

   - Continue health coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, 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.
   - (if the Health FSA is subject to HIPAA) Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing

coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. **Prudent Actions by Plan Fiduciaries**

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

4. **Enforcement of Your Rights**

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

5. **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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., 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 Pension and Welfare Benefits Administration.

Part 6. Plan Information Summary

Please refer to the Addendum attached to this document for Part 6, the Plan Information Summary.

TEHAMA COUNTY
FLEXIBLE SPENDING ACCOUNTS

SUMMARY OF MATERIAL MODIFICATIONS

The purpose of this Summary of Material Modifications is to inform you of a change that has been made to the TEHAMA COUNTY FLEXIBLE SPENDING ACCOUNTS. This change has affected the information previously provided to you in the Plan's Summary Plan Description. The Summary Plan Description is modified as described below.

1. **The Plan Sponsor** and Plan Administrator is TEHAMA COUNTY.

   Its address is 727 OAK STREET, RED BLUFF, CALIFORNIA 96080.

   Its telephone number is 530-527-4183.

   Its Employer Identification Number is 94-6000543.

2. **The Plan's designated agent for service of legal process** is the Personnel Director of the entity named in paragraph 1. Any legal papers should be delivered to him or her at the address listed in paragraph 1. However, service may also be made upon the Plan Administrator.

3. **Michelle's Law:**

The following is added to the Plan effective as of the first day of the Plan Year that begins on or after October 9, 2009:

For purposes of Code section 105(b), dependents shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

4. **Qualified Reservist Distributions are permitted: [X] Yes [ ] No**

The Summary Plan Description is revised below to describe a new type of withdrawal from Health Care Reimbursement Accounts known as a Qualified Reservist Distribution. This new withdrawal is effective March 30, 2010.

If you were a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may receive a distribution from all or a portion of your Health Care Reimbursement Account. You must make the distribution during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

5. **Dependent Care Spend Down permitted [X] Yes [ ] No**

The Summary Plan Description is revised below to describe a new ability to continue to be reimbursed from your Dependent Care Assistance Account after you are no longer a Participant in the plan.

Effective March 30, 2010, if you are no longer a Participant in the Plan (due to termination or any other reason), you may continue to be reimbursed for qualifying expenses from your Dependent Care Assistance Account through the end of the Plan Year if applicable.

FLEXIBLE BENEFIT ACCOUNT PLAN

SUMMARY OF MATERIAL MODIFICATIONS

The purpose of this Summary of Material Modifications is to inform you of a change that has been made to the Tehama County Flexible Spending Account plan.

This change has affected the information previously provided to you in the Plan's Summary Plan Description. The Summary Plan Description is modified as described below.

Health Care Reimbursement Account

1. Effective January 1, 2011, medicines or drugs are eligible expenses for reimbursement under your Health Care Reimbursement Account only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. Eligible expenses for reimbursement under your Health Care Reimbursement Account generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Care Reimbursement Account.

2. The maximum you may contribute to your Health Care Reimbursement Account in any Plan Year is $2,500.

3. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 26. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

Grandfathered Plan Notice

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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