SUMMARY PLAN DESCRIPTION

For Your

SECTION 125 FLEXIBLE BENEFITS PLAN

Aviben

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TABLE OF CONTENTS

INTRODUCTION

This Summary Plan Description must be reviewed in tandem with your Plan Document and Adoption Agreement, which contains the features that your Plan offers.

What is this Plan about?

Eligible employees are allowed to participate in a Flexible Benefits Plan ("Flex Plan" or "Plan") if offered by their Employer. A Flex Plan is an employee benefit that allows you to be reimbursed for certain expenses incurred by you, your spouse, and/or dependent(s) on a tax-free basis. You save federal, state, social security and Medicare taxes on those dollar amounts, thus increasing your take-home pay. Flex Plans are part of the U.S. Internal Revenue Code (IRC) and are designed to give employees the opportunity to pay for certain eligible living expenses with tax-free dollars.

Some of the benefits provided on a pre-tax basis are provided under separate plans or programs (e.g., your Employer's group health plan or other group arrangements). This summary generally does not provide the full detail of these other benefit plans. For information on such plans, please consult the separate Summary Plan Descriptions for such plans. This Summary Plan Description does, however, describe the benefits available under your Employer's Dependent Care Flexible Spending Account and Health Flexible Spending Account plans (herein collectively the "Flexible Benefits Plan") in full detail and shall constitute the Summary Plan Description for those benefit arrangements to the extent such a summary is required by law.

The Definition of Dependent

The definition of dependent will vary in accordance with federal and/or state law. You should always confer with your tax preparer or tax consultant in an effort to determine whether you have an eligible dependent or not. Your tax consultant shall refer to IRC 152, IRC 223, IRC 129, IRC 105(b), and IRC 106, when determining dependent eligibility for this Plan and its benefits.

In general, for purposes of the Flexible Benefits Plan, Premium Only Plans, and Medical FSA, "tax dependent" generally includes an individual who falls into one of the categories outlined in paragraphs 1, 2, or 3 below:

1. An individual who:
    a. Is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child or child placed for adoption); and
    b. Has not attained age 27 by the end of the tax year.
2. An individual who:
    a. Is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

b. Has the same principal place of abode as you for at least one-half of the relevant year;

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

d. Did not provide over half of his/her own support during the relevant year;

e. Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico;

f. Is younger than you; and

g. Does not file a joint tax return with his or her spouse.

3. An individual who:

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

b. Has received more than one-half of his/her support from you during the relevant year;

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

d. Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

For the Health Savings Account refer to IRC 152 not IRC 105(b) for definition of dependent. For the Dependent/Daycare Flexible Spending Account refer to the "Benefits" Section of this document or IRC 129.

The Definition of Spouse

"Spouse" means, for purposes of this Plan and each underlying Benefit available under this Plan, an individual who is legally married to a Participant (and who is treated as a spouse as recognized to be legally married under the Code). In some circumstances this definition may include same-sex marriage partners. Again, check with you tax consultant if you have any questions.

What Benefits Does the Plan Offer Me?

Your Employer adopted this Plan to provide you with the flexibility to elect among permitted taxable benefits and qualified nontaxable benefits offered through this Plan for the Plan Year. Specifically, you may elect to receive your normal compensation in cash or to reduce that compensation to receive Employer-provided coverage on a pre-tax basis for:

1. Premium Payment options, including medical, dental, vision or prescription coverage under your Employer's Group Health Plan or other benefit plans (which are incorporated by reference)

2. Flexible Spending Arrangements (collectively, the "FSAs")

    - Full-Use Health FSA

        - *You are only eligible to participate in the Full-Use Health FSA if you are eligible to enroll in an employer-sponsored group health plan either provided through your employer or your spouse's employer. You need not be enrolled in the offered insurance just eligible for the coverage.*

    - Limited-Use Health FSA

    - Daycare/Dependent Care FSA

    - Outside Health Insurance FSA

3. Health Savings Account

4. Group Term Life and Disability Insurance

5. Cash-in-lieu of Benefits (taxable benefit)

A more detailed description of these benefit categories are provide in this Summary Plan Description under the "Benefits" section.

How are Health Insurance Premiums Paid?

Your share of any employer-sponsored health or dental insurance premium that is deducted from your paycheck will automatically be deducted and paid on a pre-tax basis after the Plan Year begins. In the unlikely event you don't want this part of the benefit, you must submit an Election to Waive Receipt of Fixed Expenses Form available from Aviben.

How Do I Participate?

To participate in the FSAs, you must elect these benefits during open enrollment before the beginning of the Plan Year to your employer. To do this you should make a conservative estimate of the expenses you will have in each category during the Plan Year. It is important to predict your expenses as accurately as possible because the tax regulations that govern flexible benefits plans require that you "use it or lose it." This means if you overestimate your expenses you will forfeit any unused funds at the end of the Plan Year. You should, therefore, make an election for the expenses you expect to incur. Guessing is not recommended nor is trying to increase your tax savings by electing more than you are fairly certain you will spend.

Open enrollment for your Section 125 Flexible Benefits Plan will be announced by your employer and a deadline for submitting your elections will be given. Open enrollment will generally take place on-line using Aviben's web-based system. You will be provided with additional instructions regarding enrollment.

During the Plan Year you will incur the expenses. Remember that the expenses or services must occur during the Plan Year, which may or may not include a "grace period". It does not matter when you pay for them. You cannot be reimbursed for expenses or services that occurred before the Plan Year began or after it ended.

What If I Don't Elect Before the Start of the Plan Year?

If you missed the deadline established by your employer, you have no recourse. You will be deemed to have elected $0 for the FSA expenses for the year. There are however three ways you can later elect. The first is if you have a "Change Event". Change events are described in more detail later in this Summary Plan Description. The second is if you are a new employee. New employees have 30 days to elect in the Plan. If the new employee makes his/her election within the 30 day deadline the election will be retroactive to date of hire. The third is if you are entitled to a special enrollment right under the Health Insurance Portability and Accountability Act (HIPAA).

What Do I Agree to When I Participate?

You agree to: (a) observe all Plan rules and regulations; (b) consent to inquiries by the Plan administrators of any insurance company, federal, state, or local governmental agency, or provider of daycare or dependent care, medical services, or insurance; (c) file accurately all forms and furnish any data which may be required by Aviben or your employer; and (d) be liable for any tax, penalty, and interest that might be imposed with respect to your benefits by any federal, state or local revenue agency as a result of (1) misstatements or mistakes by you or (2) inadvertent over-reimbursements made by the Employer or Aviben. When submitting paper claims you must complete the Reimbursement Claim Form, sign the Reimbursement Claim Form and attach proper receipts in order to be reimbursed.

What Happens to My Pay?

Over the course of the Plan Year, there will be pre-tax salary reductions equal to your total annual election. Tax-free reimbursements will be made for any expenses you submit. We call the tax-free reimbursement of combined expenses "reclassification," since it changes your income from taxable to tax-free. The schedule for pre-tax salary reductions is established by your employer. Usually, there will be a pre-tax salary reduction equal to your total election, divided by the number of pay periods you have in the Plan Year. Your tax-free reimbursement schedule will depend on what service option your employer has established for your Plan.

Example of How the Plan Works

Dave Brown earns $35,000 per year. During the Plan Year he will spend $1,200 for payroll-deducted health insurance. He will spend $500 for medical and dental expenses, and $2,300 in day care expenses. The following chart shows how Dave will increase his take-home pay by using the Plan to reclassify his pay from taxable to tax-free.

Without a Plan	Dave Brown's:	With a Plan
$ 35,000	Annual Income	$ 35,000
	Pre-tax Eligible Expenses	$ -4,000
$ 35,000	Taxable Income	$ 31,000
$-11,778	Taxes # 33.65% (assumed: Federal 20%, State 6%, and FICA 7.65%)	$-10,432
$ -4,000	After-Tax Eligible Expenses	
$19,222	Dave's Take-Home Pay	$20,568
Dave's Increased Net Pay		$ 1,346

When considering what the Plan might do for you and your family, remember the tax savings are based on your particular taxable income level. Most employees can expect to see combined Federal, FICA and state tax savings of 25% or more on the amounts they elect to have reclassified through the Plan.

BENEFITS

Please refer to your Adoption Agreement or Open Enrollment materials for the list of Benefits that are available to you. The following section will give a description of how the benefits your Employer has adopted will be administered.

A. Payroll-Deducted Health Insurance Premiums

Also referred to as Premium Only Plan or POP Plan: This includes any medical, HMO, dental, vision, and other health coverage premiums paid by you through payroll deductions. Any health or dental insurance premium that is deducted from your paycheck will automatically be deducted pre-tax after the Plan Year begins. In the unlikely event you don't want this part of the benefit, you must submit an Election to Waive Receipt of Fixed Expenses Form to your employer.

B. Flexible Spending Arrangements

Full-Use Medical FSA: First and foremost, in order to be eligible to participate in the Full-Use Medical FSA you must be eligible to receive an offer of employer-sponsored group health insurance from your employer or through the employer of a family member. You must only be eligible to participate in the employer-sponsored group health plan you do not have to be enrolled in the plan to be eligible for the Full-Use Medical FSA.

You may flex for most health care expenses not covered by your insurance incurred by you, your spouse and dependents. These expenses are referred to as your out-of-pocket medical expenses. These expenses must be incurred as a result of an illness, treatment, diagnosis or injury. The treatment may also be as a result of preventing or treating a physical or mental defect or illness. Expenses incurred solely for cosmetic purposes are not eligible. Some cosmetic surgeries may be eligible provided they are the result of a disfiguring disease, accident, trauma or birth defect. In these circumstances a "Letter of Medical Necessity" is required. Co-pays and deductibles under any medical, dental, or vision plan are also eligible. Some over-the-counter items may also be eligible. Items purchased for your general well-being or for purposes of personal hygiene (e.g., toothbrushes, shampoo, lotion, toothpaste, mouthwash etc.) are not eligible.

"Qualifying Medical Care Expenses" include, for example, expenses you have incurred for:

(a) Medicine and drugs if such medicine and drugs are prescribed drugs or insulin.
(b) Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
(c) Medical examination, x-ray and laboratory service, and insulin treatment the doctor ordered.
(d) Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
(e) Hospital care (including meals and lodging), clinic costs, lab fees.
(f) Inpatient medical treatment at a center for drug addicts or alcoholics (including meals and lodging).
(g) Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
(h) Weight-loss program participation expenses only if the purpose of participation is to treat a specific disease or diseases as diagnosed by a physician (written recommendation of physician due to diagnosis is required). Diet food items are not a Qualifying Medical Care Expense.
(i) Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place

you received the care; or you can claim mileage at the rate listed in IRS Publication 502, located at www.irs.gov. Add parking and tolls to the amount you claim under either method.

You CANNOT obtain reimbursement for:

(a) The basic cost of Medicare insurance (Medicare A).
(b) Life insurance or income protection policies.
(c) The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.
(d) Nursing care for a healthy baby.
(e) Illegal operations, treatments or drugs.
(f) Travel your doctor told you to take for rest or change.
(g) Funeral expenses.
(h) Insurance premiums.
(i) Long-term care expenses.
(j) Expenses that are paid for pre-tax.

Orthodontic services are an eligible expense under your Medical FSA. Your Plan Document allows for reimbursement of orthodontia expenses over the course of the Plan Year as the patient is being actively treated. If you make a reasonable down payment at the onset of treatment you may be reimbursed up to $2,000.00 immediately. Other than the initial down payment, you will be reimbursed as treatment is received or in installments. Please refer to the "Orthodontia Worksheet" available on the Aviben website for assistance in calculating your election for the Plan Year.

Limited-Use Medical FSA: This flex category shall be utilized by you if you are enrolled in a High Deductible Health Plan (HDHP) and you and/or your employer are making contributions for you into a Health Savings Account (HSA). This category shall be used to cover eligible vision and dental out-of-pocket expenses only.

Over the Counter Items (OTC)

Health Flexible Spending Accounts were impacted as a result of Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020. Effective January 1, 2020, reimbursement using a Health FSA is allowed for over-the-counter (OTC) drugs or medicines, as well as menstrual products, without a prescription.

The dual purpose items (e.g., nasal strips, massage, gym memberships, vitamins, herbal supplements) will continue to require a Letter of Medical Necessity which must be updated annually.

Eligible Expenses

For more information on eligible expenses please refer to the Aviben website at www.aviben.com and view the "FSA/HRA Store." This is updated frequently to reflect law changes and formal and sometimes informal revenue rulings. The website will outline for you whether a medical expense is "eligible", "not eligible", or "potentially eligible".

Cap on Full-Use and Limited-Use Medical FSAs

The Patient Protection and Affordable Care Act of 2010 established an annual election cap on the Full-Use and Limited-Used Medical FSAs indexed annually at the discretion of the IRS. This cap is not a household cap, it is a per participant cap. Hence, if you and your spouse have the opportunity to flex in a Medical FSA you may both elect up to the new cap. Please review your Adoption Agreement to determine when the cap for your Medical FSA shall be implemented. The cap for plans in 2020 and 2021 is $2,750.

Daycare and/or Dependent Care FSA: The maximum amount you may elect in this category is $5,000 per year ($2,500 if you are married and filing separately). Expenses must be incurred during the Plan Year, and you must be working or looking for work in order for the expense to be eligible. So, if you are a teacher and decide to take the summer months off, you may not flex for expenses incurred during the summer months. However, if you are taking classes during the summer to get your masters, doctorate, or teaching certification, your expenses in this category would be eligible. You may not be reimbursed for a daycare/dependent care expense until the expense is incurred.

An eligible dependent is defined by the IRS for this category as follows:

- A child who is under age 13 for whom you claim an exemption on tax forms;
- A dependent who is physically or mentally not able to care for himself/herself and who relies on you for more than half of his/her total support in a year; or
- A spouse who is physically or mentally not able to care for himself/herself.

You cannot be reimbursed for dependent care payments to (1) your child who is under age 19 at the end of the taxable year in which the payments are incurred or paid, or (2) anyone who could be claimed as a dependent on your federal income tax return for the taxable year in which the payments are incurred or paid.

You can be reimbursed for dependent care payments to other relatives. However, you can't modify your dependent care election based on a cost increase if the provider is a relative. Make sure your relative is claiming the fee you are paying them as income.

Dependent/Daycare Care FSA eligible expenses include the following:

- Adult daycare centers
- Summer day camp (overnight camp is not eligible)
- Child daycare
- Extended day/latch key
- Nursery school
- Preschool
- Kindergarten is NOT an eligible expense

- "Hold your spot" fee

Monies set aside for dependent or daycare may not be used for other purposes such as medical reimbursement or outside health insurance.

Monies that you flex for dependent care expenses may not be used for the dependent care tax credit on your federal income tax. For more information on the dependent care tax credit refer to the "General Information" section of this Summary Plan Description.

Limited Excepted Benefit Health Insurance Premiums:

Employees may flex for the cost of individually owned limited excepted benefit insurance policy, such as dental or vision policies (not a group policy) in this category. This was previously referred to as Outside Health Insurance, but the name was causing confusion on what was actually covered. To be eligible for this benefit, the policy must belong to you, your spouse or legal dependent(s), and the premium must be paid with after-tax dollars. This does NOT include individually owned health insurance policies, an individually owned supplemental policy, or any policy that is currently being paid on a pre-tax basis through a payroll deduction. The Affordable Care Act (ACA) precludes the use of 125 Plan pre-tax dollars to be used to purchase or reimburse the cost of an individual to purchase an individual health insurance policy through a Public Health Insurance Marketplace commonly referred to as the "Exchange". This includes state and federally run Exchanges.

You may not flex for the cost of a health insurance policy if the cost is currently being paid on a pre-tax basis through a payroll deduction. An employer may forward after-tax employee wages to a health insurance issuer to purchase individual coverage if the employer wishes to allow this practice.

If you flex your premium cost in this category, you may not use the premium cost for a deduction on your income tax.

Some examples of the types of insurance that may qualify include: accident insurance, cancer insurance, vision insurance, dental insurance, and hospitalization insurance

Some examples of types of insurance that are NOT eligible in this category are long term care insurance, individual health insurance, Medicare supplement plans, any plan purchased through a public exchange, any plan paid for with pre-tax dollars (e.g., as a salary reduction).

Please be aware that the Affordable Care Act and specifically IRS Notice 2013-54 and 2015-17 significantly changed what expenses are eligible in this category of the Flex Plan. Below is a specific summary list of what is and is not currently an eligible expense in the Outside Health Insurance FSA category of the Flex Plan.

<u>What is eligible in the outside health insurance category:</u>

- Cancer policy premiums
- Accidental Death and Dismemberment policy premiums
- Specific Illness policy premiums

- Vision policy premiums (if purchased as individual policy with after tax dollars)
- Dental policy premiums (if purchased as individual policy with after tax dollars)
- Hospitalization insurance policy premiums
- Disability insurance policy premiums
- Employer-sponsored group term life insurance policy premiums (premium cost that provides up to $50,000 for employee only)

What is NOT eligible in the outside health insurance category:

- Health insurance public exchange (in MN called MNSure) health insurance premiums
- Health insurance policy premiums purchased in the individual market
- Medicare policy premiums (Part A, B, C, D, and Medicare Supplement)
- Health insurance policy premiums for group health care policies from your own employer or from another family members group health policy from their employer
- Long term care premiums
- Any health insurance premium that has already been paid on a pre-tax basis

Health Savings Account Contributions (Payroll-Deducted: If your employer has implemented a High Deductible Health Plan (HDHP) that qualifies you for a Health Savings Account (HSA) option you may be able to contribute to your HSA on a pre-tax basis through this Plan.[1] When you make an election to contribute to your HSA through this Plan, your election amount will be pro-rated based on the number of pay periods you have during the Plan Year. It is your responsibility to stay within the HSA contribution limits established by the Internal Revenue Service each tax year. All contributions into your HSA, employee and employer, count toward the limit. Also, be aware, that moving in and out of HDHP eligibility will also impact the amount you can contribute to your HSA. Also, if you are age 55 and over, you may make an additional contribution amount, which is subject to change by the IRS.

When you contribute to your HSA through your employer's Plan, your contribution amount will be disclosed every year on your W-2. If you exceed your contribution limit for the tax year the overage is included in your gross income and an excise tax of 6% is charged on the overage.

Your employer will allow you the opportunity to change your HSA election at least once a month. Changes to election amounts can only be made prospectively. You do not need a "change event" to make a change in this benefit category.

Similar to the Medical FSA, funds set aside in this account are to be used for eligible medical expenses. Distributions from your HSA for non-medical expenses are included in gross income and taxed and an additional 20% penalty will be applied. However, if you are age 65 or older, disabled, or die, no penalty is assessed for non-medical distributions, but the non-medical distributions will be taxed as taxable income.

You are responsible for maintaining receipts of purchase to prove whether distributions were made for medical or non-medical expenses. Unlike the Medical FSA, you may use HSA funds to pay for COBRA premiums and long term care premiums. If you are age 65 and older, you may also use HSA funds to pay for the employee share of the premium cost of employer-

[1] Refer to the Adoption Agreement to determine whether your employer has adopted this component benefit.

sponsored health insurance and Medicare Part B and D. Otherwise, health insurance premiums are not an eligible expense.

You will not be submitting claims and receipts to your employer or Aviben for review and reimbursement. You will receive a debit card and/or checks in order to extract monies from your HSA.

Group Term Life Insurance: The premium for the first $50,000 of **employer-sponsored** group-term life insurance is paid tax-free. Any death benefits from the insurance are also income tax-free. Insurance coverage above $50,000 is taxed based on IRS tables. Even then, the amount taxed may be less than the actual premium cost. Again, any death benefits your family receives under the insurance are income tax-free. Other individually-owned life insurance policy premiums are not an eligible expense.

Cash In Lieu of Benefits: An Employer may provide a contribution to employees to be used for the benefits provided with the employer's Flexible Benefits Plan or within the Premium Only Plan. If said employer contribution is not allocated, in whole or in part, to any of the available variable benefits or the Premium Only Plan a cash payment may be made to the eligible employee. The cash payment to the participant shall be taxed. The employer may also subtract from the cash payment the employer's share of the FICA cost. Please refer to your Adoption Agreement regarding the details of your employer's Plan.

LIMITS ON BENEFITS

What limitations are there for elections and reimbursement of expenses?

There are several:

1. **Benefits Ceiling**. Your benefits can't be greater than the "Benefits Ceiling," defined as the lesser of (a) your compensation, or (b) $20,000 (unless a different amount is shown on the Adoption Agreement) plus the cost of all salary reduction insurance.

2. **Dependent Care Limitations**. Dependent Care Plan benefits are subject to the following limitations:

   (a) "Earned income" limitation. Dependent care expense may not be greater than (a) if you're not married, your earned income, or (b) if you're married, the lesser of your earned income or your spouse's earned income. If your spouse is a student or incapacitated, please refer to IRS Form 2441, "Child and Dependent Care Expenses" for instructions on computing earned income. "Earned income" doesn't include income from rents, royalties, interest, dividends and capital gains.

   (b) Overall dependent care benefits ceiling. You may not elect more than $5,000 of dependent care expenses under the Plan ($2,500 in the case of a separate return by a married individual). The ceiling is reduced by any amounts directly reimbursed to you by the Employer.

3. **Overall limitations for highly compensated employees**. HCEs may not receive more of all said benefits than are provided to all employees. If this test is violated and you are an HCE, you may be forced to reduce your election, your reimbursements, or both. If this test is violated, any qualified benefits received under the Plan by an HCE for a Plan Year shall be included in the gross income of such employee for the taxable year within which such Plan Year ends. Other possible consequences of discrimination are beyond the scope of this summary.

   (a) 55% Rule. If you're a highly compensated employee ("HCE," defined below) and the average dependent care benefit provided to employees who aren't HCEs is less than 55% of such benefits provided to HCEs (disregarding in either case employees whose compensation is generally less than $25,000), you may be forced either to reduce your election, reduce your reimbursement requests for dependent care expense during the year, or do a combination of the above. This factor probably won't affect the amount you decide to elect for dependent care expense, even if you are a HCE, because having to reduce your dependent care expense benefits to a lower amount will leave you no worse off than if you had elected that lower amount in the first place.

What is a "highly compensated employee" (HCE)?

The Internal Revenue Code generally defines a HCE for any year as one whom:

1. Had compensation for the preceding year in excess of $130,000 (indexed for inflation); and
2. If the employer so elects, if the employee was also in the top paid 20% of the employer's employees (ranked on the basis of compensation paid during the preceding year subject to certain exclusions).

EMPLOYER LIABILITY LIMITS

What limits on liability apply?

If the Employer fails to obtain insurance contemplated by this Plan, the Employer's liability shall be limited to the insurance premium, if any, unpaid for the period in question. The Employer's limit in exposure for losses or obligations with respect to insurance coverage is as follows:

1. The Employer shall not be liable for failure to pay insurance premiums to the extent premium notices are not received by the Employer.

2. To the extent premium notices are received by the Employer, the Employer's liability for the payment of premiums shall be limited to the amount of such premiums.

3. Upon a Participant's separation from service, the Employer shall have no obligation to take further steps to maintain any insurance policy in force beyond any required by law. The Employer shall not be liable for the payment of any premium after a Participant's separation from service.

CHANGE EVENTS & ELECTION MODIFICATIONS

When may I change my election during a Plan Year?

You can change your election only if you have a "Change Event." A Change Event is an event that, under the law and the terms of the Plan, permits election changes. (See below.) ***Please keep in mind that any and all of these changes need to impact eligibility in order to be a Change Event.***

Upon the happening of a Change Event, you can change your election, *but only in a way that is consistent with the Change Event.* This is sometimes referred to as the "Consistency Rule."

How do I change my elections?

For all Plan benefits, except payroll-deduction insurance, you can change your election by filing the Election Change Form with your employer or Aviben. For payroll-deduction insurance, you can change your election by filing the Change Notice with your employer or Aviben at the time you change your insurance coverage.

Can you give examples of the Consistency Rule? Here are some:

1. A dependent dies or loses or gains eligibility for coverage under your spouse's health insurance. While you may change your election to adjust for that dependent's situation, you may not modify your election to add or remove coverage under the Plan for another dependent.

2. You marry during the Plan Year. You may change your election to: (a) add coverage for your spouse; (b) elect Health FSA coverage for your spouse; or (c) drop coverage for yourself under the Plan in order to be covered under your spouse's insurance.

3. Your child is going to turn age 27 within the tax year and loses eligibility for your health insurance under the Plan. You may change your Plan election to switch from family to individual health coverage or drop health insurance coverage for your child.

What are "Change Events"? They include the following:

1. **Cost Change.** A significant cost increase or decrease in a premium for health coverage provided by an independent third-party provider, or a significant increase or decrease in cost imposed by a dependent care provider if the dependent care provider is not your relative.[2] A change in cost is not a Change Event for the Medical FSA category.

2. **Coverage Change.** A significant curtailment or cessation of coverage under a health plan provided by an independent third-party provider during a period of coverage, or a significant change in health coverage of you or your spouse attributable to your spouse's employment, or a change in a provider of dependent care assistance or the dependent being enrolled in school during the Plan Year. A change in coverage is not a Change Event for the Medical FSA category.

3. **Change in Status**: One of the following Changes in Status:

   (a) Change of marital status, including marriage, death of spouse, divorce, legal separation or annulment.

   (b) Change in number of tax dependents, including birth, adoption, placement for adoption, or death.

   (c) Change of employment status, including termination or commencement of employment by you, your spouse or dependent.

   (d) Change of work schedule, including any of the following that affect the employment status of you, your spouse or dependent: a reduction or increase in hours of employment, a switch between part-time and full-time, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite.

   (e) Dependent satisfies or ceases to satisfy health plan requirements for unmarried dependents, including attainment of age, student status or any similar circumstance as provided in your health plan.

   (f) Residence including a change in the residence of you, your spouse or dependent.

4. **Special Enrollment Right.** A special enrollment right under HIPAA arising when health coverage is terminated described below.

[2]For this purpose "relative" means descendent, ancestor, stepchild, sibling, step-sibling, step-parent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law. In determining who is your relative for this purpose, children who are adopted or placed for adoption by an authorized placement agency, as well as foster children who live with their foster parents, are treated the same as other children, and half-siblings count as siblings.

5. **Judgment, Decree or Order.** A Judgment, Decree or Order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your dependent child or foster child.

6. **Medicare/Medicaid.** A gain or loss of Medicare or Medicaid eligibility.

Are retroactive changes permitted?

Retroactive changes are only permitted after the birth or adoption of a child or if you are a new employee. In these two instances, a participant has a 30-day grace period to increase or make elections.

When am I entitled to special enrollment rights?

You may be entitled to special enrollment rights if:

1. You decide before the beginning of the Plan Year not to elect a particular benefit because you or your dependents are covered under another plan (such as your spouse's health insurance policy); and

2. Coverage under that other plan is later terminated because either:

   (a) The coverage was continuing coverage under COBRA (the law which lets an employee continue benefits after employment is terminated) and the COBRA coverage is exhausted; or

   (b) The coverage was not under COBRA and was terminated because of (1) loss of eligibility for coverage, or (2) the cessation of employer contributions for the coverage.

How do I exercise special enrollment rights?

Within 30 days after coverage under the other plan ends, you submit an Election Change Form electing coverage under the Plan to replace the coverage you lost under the other plan. As usual, the changed election must be consistent with the loss of coverage under the other plan, thus meeting the Consistency Rule.

SEPARATION FROM EMPLOYMENT

What happens if I separate from service?

You **MUST** complete and submit your Separation Form prior to your separation date. You thus can get the maximum benefit to which you're entitled, and therefore the most tax savings.

If you want to continue to be covered for your elections, you can have those costs taken out of your last paycheck. (Other payment methods may be possible, but would not generate any tax

savings since they would not reduce your taxable pay.) You can then be reimbursed for these expenses as you submit them.

If you don't elect continuing coverage, you revoke your election when you separate from service. Health FSA expenses incurred after revocation will not be eligible for reimbursement. Other FSA expenses incurred during the Plan Year can be reimbursed after revocation, but only up to the amount of your cumulative salary reductions as of your separation date.

If you separate from employment and return in the same Plan Year, you cannot make a new election for the rest of the year. However, if you are rehired within 30 days of termination, your previous election will be reinstated.

What about continuing health coverage?

Under the Plan, the reason you save money is that you reduce your taxable pay in exchange for tax-free reimbursements. After you separate from service, you are left with no taxable pay to change to tax-free reimbursements. This means that if you haven't paid for coverage by the time you separate from service, you must use after-tax dollars to pay any balance owing. Since the savings from the Plan arise because you pay for benefits with pre-tax (and not after-tax) dollars, coverage paid for after you leave service will not save taxes. You would also have to pay at least $1.02 or as high as $1.50 for $1.00 of continuation coverage.

DEPENDENT CARE TAX CREDIT

What is the dependent care tax credit?

This is a credit against your taxes based on the amount of your dependent care expenses and your taxable income. The amount of the credit can vary from individual to individual.

Is it better to take the dependent care tax credit or receive dependent care reimbursement?

The answer to this question will depend on your tax bracket (for federal, state, FICA and Medicare taxes), on how much you pay for dependent care and on the amount of federal, state and local tax benefit you would receive for the dependent care expenses you expect to incur. You should project your taxes both ways, with the credit and without the credit, before you make your decision. This is because the credit may be more or less than the value of the exclusion under this Plan. If you have only one qualifying child or dependent, your ceiling for the credit is $3,000, compared to $5,000 ($2,500 if you are married filing separately) under the Plan. The maximum amount upon which you may have a tax credit on your tax return ($3,000 for one and $6,000 for two or more "qualifying individuals") is reduced by the amount you get tax-free under the Dependent Care Reimbursement Plan.

Can I be reimbursed for payment to a relative for dependent care?

You cannot be reimbursed for dependent care payments to (1) your child who is under 19 at the end of taxable year in which the payments are incurred or paid, or (2) anyone who could be claimed as a dependent on your federal income tax return for the taxable year in which the payments are paid or incurred. You can be reimbursed for dependent care payment to other relatives. However, you can't modify your dependent care election based on a cost increase if the provider is a relative. (See section on election modification.)

ADMINISTRATIVE OPTIONS

Services

Your Employer has contracted with Aviben to provide certain services. All claims and reimbursement of all claims shall be administered by Aviben. You may submit claims to Aviben through any of the following options:

- Submit Mobile App Claims
- Submit Web Claims
- Mail in Paper Claims
- Fax in Paper Claims
- Prepaid Benefits Card provided by Aviben

The IRS requires that all claims be adjudicated by a third party administrator. A participant is not allowed to self-certify any expenses. Proof of the expense must be provided by the actual service provider.

Reimbursement Options

Claims

Administrators must follow IRS substantiation guidelines for electronic and paper claims alike. All receipts accompanying a claim shall provide to the Administrator the following information:

- ***Date of service or purchase; and***
- ***Description of product or service; and***
- ***Cost of product or service; and***
- ***Whom received the product or service purchased or provided***

If a receipt does not provide the Administrator with the information bulleted above, the receipt does not substantiate the expense. The Participant will receive a "Letter of Non-Paid Claim" or a notification requesting a proper receipt or additional information. Until a proper receipt is received, the expense has not been substantiated and shall not be paid. A proper receipt does not include a cancelled check or a check carbon. A receipt must be provided through the service or product provider. Participants cannot self-certify an expense. A statement that provides a balance forward does not qualify as a proper receipt unless all the bulleted items listed above are clearly provided on that statement.

Prepaid Benefits Card

Some Employers will provide the opportunity for participants to use a "Prepaid Benefits Card", hereinafter referred to as the "Card", to reimburse for eligible health care expenses. Ask your employer if this is an option for your plan. Since the IRS requires that 100% of Flex claims be substantiated, the IRS provides a number of approved auto-substantiation methods to meet that goal at approved merchants.

1. *Approved Merchants*

   The Card can be used to pay for eligible medical items at merchants using the Inventory Information Approval System (IIAS). **Transactions at these merchants are fully substantiated and no paper follow-up is needed**. A list of IIAS Merchants is available on our website at www.aviben.com. Click on the Benny Card link and then click on the List of Participating Merchants link.

   The Card may also be used at merchants that have been identified through a Merchant Category Code system (MCC). These merchants are eligible because 90% of their revenue is from sales of medically eligible items. These merchants are sometimes referred to as 90% merchants. Transactions at these merchants are substantiated via the following IRS approved methods:

   - **Co-pay matching** – Entered in our system from information given to us from the employer

   - **Recurring expense logic** – A pattern is noticed by the system for the same payment amounts, (e.g., monthly orthodontia payments)

   - **After-the-fact substantiation** – Letters or e-mails are sent out to participant requesting receipts to verify the expense. When the Cardholder uses the Card to pay for eligible items at an IIAS merchant that accepts Visa®, eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated and no paper follow-up is needed. The Card can also be used to pay a hospital, doctor, dentist, or vision provider that accepts Visa®. The Plan uses IRS approved auto-substantiation technology to electronically verify the transaction's eligibility.

   To assure compliance with IRS regulations, the Card uses the ***maximum*** electronic substantiation capabilities to drive the ***minimum*** amount of paper. At the point of sale, the Card screens transactions first by availability of IIAS and by MCC, enabling Aviben to disallow use of the Card in locations that do not relate to the benefits (e.g., gas stations). The Plan offers the following substantiation options:

2. *All IRS Approved Auto-Substantiation Solutions Utilized by Aviben:*

Merchants Using Inventory Information Approval Systems (IIAS) – When the Cardholder makes a purchase at a merchant using IIAS, the merchant's system automatically recognizes and separates Medical FSA-eligible from non-eligible purchases. Eligible purchases can be placed on the Card, and the consumer is asked for an alternative payment method for ineligible items. The IRS mandated that pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets all have to use IIAS to continue accepting benefits debit cards.

Patented Real-Time Data Matching at Point of Sale – The Card has in place direct data links with the premier pharmacy benefit managers (PBMs). Real-time substantiation occurs during the Card swipe authorization in the pharmacy prior to the transaction's being approved and requires no special handling on the part of the merchant or Cardholder. The Card transaction is matched to the claims data at the point of sale. If they match, the Card swipe transaction is approved and considered substantiated, requiring no further action. If the transaction cannot be matched, it is declined. This method is ideal for plan designs that require more information than is available through IIAS alone, for example, insurance plans with a restricted prescription formulary.

Retrospective Data Matching – Paid Card transactions are compared to adjudicated claims from health plan, vision, and dental carriers. If they match, the Card swipe transaction is considered substantiated and requires no further action. The Card provider currently receives feeds from over 150 carriers.

Employee-Level Copayment Matching – Aviben collects employee copayment information from the employer and provides it to the Card administrator, which matches it retrospectively against the Card transactions. The Card system automatically calculates multiple and combination copayments (up to 5) consistent with IRS guidelines.

Recurring Expense Logic – After a transaction has been substantiated once, transactions for the same amount in the same setting are substantiated electronically and do not require another review.

3. *The Card and OTC Drugs and Medicines*

Effective January 15, 2011, in accordance with IRS Notice 2011-5, the following four requirements need to be met in order for the Prepaid Benefits Card to automatically substantiate purchase of OTC drugs and medicines at point of sale:

1. Prescription is presented (in any format) to pharmacist;

2. Store retains a record of the Rx Number

    a. Name of person, date, and amount of purchase;

3. All records are available to Participant and Third Party Administrator; and

4. Prepaid Benefits Card system shall not accept a charge for OTC unless an Rx number has been assigned.

If the first three requirements are met, your Prepaid Benefits Card should function properly.

4. *When Auto-Substantiation Methods Are Not Available or Fail*

If the Card is unable to substantiate the transaction automatically after applying all the IRS-approved methods, the Cardholder will receive a letter or e-mail requesting a receipt to ensure compliance with IRS substantiation regulations. The Card's management system provides full support to the Plan Administrator for this process. The Plan Administrator will send out two notices (mail or e-mail) for substantiation then the Card will be suspended until receipts are received or funds are returned.

5. *When Paper Claims Are Necessary*

Although using the Card will automatically adjudicate the majority of transactions, in cases where the Card isn't used, the Cardholder can pay by other means and apply for reimbursement using Aviben's normal manual claims process. All Card transactions and related balances are synchronized using file interfaces. The single database holding the Participant's information is updated to reflect both the Card swipe transactions and any paper transactions that Aviben has manually processed and are pending for payment.

6. *Card Reporting*

Aviben has access to Card transaction and account usage activity in real time and uses it to monitor the daily efficiency of Card processing. Daily reports are provided to Aviben through a secure URL.

7. *Card Activation*

The Card system captures the production and mail dates for each Card so Aviben can respond to customer inquiries. Following best practices for Card security, Cards are not active when delivered. Prior to first usage, the Card must be activated by either calling the Interactive Voice Response (IVR) toll-free number or accessing the web site listed on the Card. Upon activation, both Cards will be available for use. By activating the Card, Cardholders consent to abide by the Cardholder agreement.

8. *Participant Enrollment*

Eligible Participants may sign up for the Card at any time during the Plan year after the Card has been implemented by the employer. The cost of the Card will

be prorated based on the monthly cost. You must re-enroll to use the Card every year.

9. *Lost or Stolen Cards*

Cards that are lost or stolen must be reported to Aviben immediately. Lost or stolen cards will be shut off and a new Card will be reissued.

Report a lost or stolen Card via your Consumer Portal or by contacting Claim Support:

Claim Support
claimsupport@aviben.com
1-888-507-6053
1995 E Rum River Drive South
Cambridge, MN 55008

Mobile App Claims

If you have a smartphone with the ability to take a picture of your receipts, you have the ability to submit a claim through the Aviben mobile app. Download the app from the App Store or the Google Play Store. Log in to your account. Under "I Want To," click "File A Claim." Enter the requested information and upload a photo of the claim. YOU MUST UPLOAD A RECEIPT OR YOUR CLAIM WILL BE DENIED UNTIL A RECEIPT IS SUBMITTED.

If you have any troubles submitting a Mobile App Claim, please contact an Aviben Representative at 1-888-507-6053 for assistance.

Web Claims

If you have the ability to scan and save receipts to a location on your computer, you have the ability to submit a claim through the Aviben website. Once your receipts have been scanned in, you must login to the Aviben website at www.aviben.com. Click on the "Consumer Portal" and "Login" to Your Account by clicking on the button that is on the left.

Once you are logged into your account, select "File A Claim" button. Complete the requested information and Click "Next." Upload the receipts, and click "Next" again. You are also able to include any notes that you feel might be helpful. YOU MUST UPLOAD A RECEIPT OR YOUR CLAIM WILL BE DENIED UNTIL A RECEIPT IS SUBMITTED.

If you have any troubles submitting a Web Claim, please contact an Aviben Representative at 1-888-507-6053 for assistance.

GRACE PERIOD

Review your Adoption Agreement to determine whether your Employer has adopted the "Grace Period". The Grace Period adds an additional 2 ½ months to the end of your current Plan Year. The Grace Period allows for an additional 2 ½ months for you to incur expenses. Any expenses

incurred during the Grace Period shall be applied to the old Plan Year first as a safeguard against the use-it-or-lose it rule.

$500 DOLLAR CARRYOVER

Review your Adoption Agreement to determine whether your employer has adopted the "$550 dollar over" feature that applies to the Medical Flexible Spending Account only. The $500 dollar carry over cannot be used by your Plan if you have adopted the Grace Period feature described above. The $550 carryover is the overall cap that you can carry over from year-to-year you cannot build upon that amount. Please be aware that the $550 carryover feature could impact your ability to fund a Health Savings Account as described in IRC 223. If you have questions regarding how the carryover could impact your HSA please contact your plan administrator.

RUN OUT PERIOD

Your "Run Out Period" is the time you have after your Plan Year ends to submit your claim for reimbursement to your Plan Administrator. If your Plan has the Grace Period, the Run Out Period begins after the Grace Period ends or it may begin when the Plan Year ends. Check the Adoption Agreement to determine what your Plan's Run Out Period is.

GENERAL INFORMATION

What if my covered expenses during the Plan Year are less than the amounts which I elected?

You lose the difference. This is called "forfeiture". (Thus, you should make your election carefully and safely.) Your entire election amount in all FSA categories will be deducted by the end of the Plan Year. You may submit qualified expenses for reimbursement after the Plan Year end and until the Run Out Period is over. Your Consumer Portal will give you the amount of time you have to submit your claims to your Plan Administrator if you hover over the question mark next to your account balance.

What if my covered expenses during the Plan Year are greater than the amounts I elected to be reclassified?

You may only be reimbursed for expenses up to the amount of your election.

What are the tax consequences of my reimbursements?

Reimbursements of eligible expenses generally are not included in your taxable income. Expenses that are reimbursed under the Plan may not be claimed as deductions on your federal income tax return.

From where are the benefits provided?

The Plan's benefits are either taken from the Employer's general assets, or are provided through insurance policy contracts, all of which taken together may be part of this Plan.

What if I elect the right total amount of expenses but don't have them in the right categories?

You may have a forfeiture. It's important to elect expenses in the appropriate FSA categories because you may not shuffle expenses between FSAs. The risk of a forfeiture applies to each category in which you elected too high.

What changes in the Plan may the Employer make?

The Employer may at any time amend or terminate the Plan. Any amendment or termination shall be effective on the date specified and may be retroactive with or without notice to the Participants. The Plan Administrator will let you know of any significant changes made to the Plan.

Whose responsibility is it to determine ownership of, and select beneficiaries for, insurance?

Yours. These are personal estate and financial-planning issues.

To whom should legal documents and requests for information be directed?

Service of legal process may be made and inquiries for more information may be sent to your employer at the address provided to Aviben. The Plan (including all related documents) may be obtained from Aviben or your Employer for inspection and copying by any eligible individual, any employee, and any employee organization that represents employees of the employer.

What records should I keep?

You should keep your original invoices, canceled checks, bank account statements, forms you filed with the Employer, your worksheets, and this Summary Plan Description for at least 7 years after the end of the Plan Year.

SOCIAL SECURITY & OTHER BENEFITS

What about Social Security?

Amounts reimbursed under the Plan are exempt from Social Security tax as well as income taxes. If you believe Social Security benefits are worth exactly what it costs you in Social Security tax, or if you feel Social Security benefits are **not** worth what they cost you from your paycheck in Social Security tax, you're better off by having all possible qualified expenses reimbursed because under the Plan you save income taxes in addition to Social Security tax. Even if you consider Social Security a bargain (compared to Social Security tax cost), you're only ahead if the benefit of Social Security is greater than the sum of Social Security tax **PLUS** the federal and state income taxes you save.

Social Security benefits are also seen by some to be disproportionately high compared to the dollars contributed in order to **qualify** for basic coverage, but not so high compared to dollars contributed after a larger wage base has been built up. People who won't get Social Security benefits right away usually see less value in Social Security. Overall, Flex Plan reductions in the wage base are seen by many as relatively minor when compared to a lifetime of earnings. Other factors include your life expectancy, the viability of the Social Security system, the yield you get on other investments, and your age. The Social Security Administration can help you compute how much benefit you get for an additional $1.00 in your wage base. Consult the Social Security Administration and your financial advisors if you have further questions.

What other effects may there be if my taxable income is reduced?

With reduced taxable pay, you may have a lower base for unemployment compensation and workers' compensation benefits. You may or may not also have a reduced salary base for computation of contributions to any pension, profit-sharing, stock bonus, annuity or other plan provided by the Employer. Your Plan Administrator can clarify any questions you may have.

DISABILITY BENEFITS

Must I include in taxable income benefits received from disability insurance?

This depends. If you have the disability insurance premiums reimbursed under the Plan, and you become disabled, you must report the proceeds of the policy as taxable income. However, if you have never had the premiums reimbursed, the proceeds of the policy will be **tax-free**.

FILING YOUR TAX RETURNS

What happens when I file my federal and state taxes?

There is nothing extra to do at tax time unless you've elected dependent care expenses, which you must report on IRS Form 2441. You do not have to pay extra taxes because of tax savings you experienced during the Plan Year, since your W-2 will show a taxable wage reduced by the benefits elected. Thus you don't have to "pay back" tax savings you enjoyed during the Plan Year.

APPEALS PROCEDURE

What is the appeals procedure if a claim I make for expenses is denied?

If you want to appeal the Plan Administrator's denial of a claim for Plan benefits, contact the Plan Administrator. The Plan Administrator will supply any forms that might be needed. Within a reasonable time after receiving a claim, the Plan Administrator will give a written notice of the decision to any person whose claim for benefits has been denied. For this purpose, 90 days is a reasonable time unless the Plan Administrator notifies the claimant, within 90 days, of the expected date of the decision and the special circumstances which require an extra 90 days for processing the claim.

If the Plan Administrator's notice states a claimant is not eligible for any benefits or is not eligible for full benefits, the notice will provide specific reasons for the decision, including a reference to any pertinent Plan provision. The notice will also describe any other information needed for review of a denied claim. If the claimant receiving the Plan Administrator's decision believes that he or she is entitled to greater or different benefits, the claimant shall have the opportunity to have the claim reviewed by the administrative committee (made up of members designated by Plan Sponsor). This is done by filing a petition for review with the committee within 60 days after the Plan Administrator has given the claimant notice of a denial of any benefits. The petition should state the specific reasons why the claimant believes he or she is entitled to benefits or greater or different benefits. The committee will give the claimant (or a representative, if any) an opportunity to make a presentation to the committee, either orally or in writing, and the claimant will have a right to review the pertinent documents.

The committee will send the claimant its written decision within 60 days after the committee receives the petition unless the committee notifies the claimant of special circumstances requiring an extension. If special circumstances (including a need for a hearing) exist, the committee's written decision shall state the specific basis for the decision and the specific provisions of the Plan on which the decision is based.

RIGHTS UNDER COBRA AND HIPAA

What about health continuation coverage?

COBRA Continuation Coverage

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that most employers sponsoring group health plans offer employees and their families the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

If you are covered by a group health plan sponsored by your employer, you and your dependents have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part) or if you are a retiree because your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code. You do not have to show that you are insurable to continue your health coverage.

If you are the spouse of an employee (or a retiree for reason 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following five reasons:

1. The death of your spouse;

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse;

4. Your spouse becomes entitled to (actually covered under) Medicare; or

5. Your spouse's employer files for Chapter 11 reorganization.

A dependent child of an employee (or a retiree for reason 6 below) covered by the Plan, has the right to continuation coverage if group health coverage under the Plan is lost for any of the following six reasons:

1. The death of a parent;

2. The termination of a parent's employment (for other than gross misconduct) or reduction in hours of employment with the employer;

3. Parents' divorce or legal separation;

4. A parent becomes entitled to (actually covered under) Medicare;

5. The dependent ceases to be a "dependent child" under the Plan; or

6. The parent's employer files for Chapter 11 reorganization.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the qualifying event. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have at least 60 days after the later of (i) the date you would lose coverage or (ii) the date you received notice from the Employer of the right to continue your health coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to "similarly situated employees or family members." The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months because of a termination of employment or reduction in hours. If you have been determined to be disabled for Social Security purposes at the time of termination of employment or reduction in hours and have notified the Employer within 60 days of the Social Security determination and before the end of the 18-month continuation period, you may extend coverage for an additional 11 months (to 29 months). (You must also notify the Plan Administrator within 30 days of any final determination that you are no longer disabled.) If during the 18-month continuation period another qualifying

event takes place, coverage may be extended up to 36 months from the date of the original event. If you are entitled to continue coverage for any reason other than termination of employment or reduction in hours, the continuation coverage period is up to 36 months.

Your continuation coverage may be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its employees;

2. The premium for your continuation coverage is not paid in a timely fashion;

3. You become covered under another group health plan (except when the other group health plan excludes coverage for a pre-existing condition); or

4. You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. You will have a grace period of at least 45 days after you elected continuation coverage to pay any retroactive premium from the date continuation coverage starts until the date you choose continuation coverage, and 30 days in which to pay any subsequent premiums. The law says that at the end of the 18-month, 29-month or 3-year continuation coverage period, you must be allowed to enroll in any individual conversion health plan provided under the Plan. The law applies to the Plan as of the date of the Plan's adoption.

If you have changed marital status, or if you or your spouse has changed addresses, please notify the Plan Administrator. The cost of the continuation coverage is usually 102% (but can be as high as 150% if disability is the reason for the continued coverage) of the cost of coverage for similarly situated employees.

This Plan saves you money primarily because it allows you to **reclassify** pay from taxable to tax-free, thus saving taxes. After you separate from service, however, you normally would have no taxable pay from your Employer to reclassify. In order to pay for coverage after you separate from service, you normally must use after-tax dollars. Coverage after you leave the Employer's service will therefore normally not save taxes. You'd also have to pay $1.02 for $1.00 of continuation coverage. The result is that continued coverage (if available) under the Flexible Benefits Plan usually makes little sense. (However, it may make sense to continue your health insurance coverage outside the Flexible Benefits Plan if somebody in your family has a condition which can't be covered with new or replacement insurance.)

What effect could HIPAA have on my benefits under the Plan?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all individuals who terminate from a group health plan subject to COBRA must be provided with certification of creditable coverage when normal coverage terminates under the plan and again when COBRA coverage terminates. A single certification may be provided relating to all qualified beneficiaries (if the period of coverage is identical) or, if the information is not identical, certifications may be provided on one form. A qualified beneficiary under HIPAA includes the spouse and dependent children of a covered employee and, in certain cases, the covered employee. A child who is born to the covered employee, or is placed for adoption with

the covered employee during a period of COBRA continuation coverage is also a qualified beneficiary.

HIPAA also requires that group health plans provide for mid-year enrollment for certain individuals. For example, an individual who did not enroll in the Plan at the beginning of the Plan Year may make a mid-year election under the Health FSA if the individual, or a dependent of the individual, loses health coverage.

Health FSAs are not covered by HIPAA if two conditions are met. First, the maximum benefit cannot exceed the greater of (a) two times the employee's salary reduction election, or (b) the amount of the salary reduction election plus $500. Second, the employee must have other coverage available under a group health plan of the employer not limited to excepted benefits. If both of these conditions are met, the Health FSA is exempt from HIPAA.

2020-2021 POTENTIAL AMENDMENTS

The first relevant COVID relief notice, Notice 2020-29, allows mid-year election changes within a Section 125 Cafeteria plan if the cafeteria plan sponsor voluntarily amended its cafeteria plan. The plan may be amended retroactively to allow the following mid-year changes made after January 1, 2020:

1. Make a new election to participate in employer-sponsored health coverage if the employee initially declined to elect such coverage;
2. Revoke a previous election for employer-sponsored health insurance coverage and make a new election to enroll in other health coverage provided by the employer;
3. Revoke a previous election for employer-sponsored health coverage provided that the employee attests in writing that the employee will be covered by other health coverage not provided by the employer;
4. Revoke an election, make a new election, or increase or decrease an election to a health FSA; and
5. Revoke an election, make a new election, or increase or decrease an election to a dependent care flexible spending arrangement.

One of the COVID relief bills, the Consolidated Appropriations Act of 2021, was passed by Congress on December 21, 2020 and signed into law on December 27, 2020. This 5000+ page bill, among other things, grants certain voluntary changes to Section 125 Cafeteria plans with respect to Health and Dependent Care Flexible Spending Accounts (collectively, "FSAs"). The following options are available for FSAs:

1. Permit employees to carryover unused amounts in the FSAs from the 2020 plan year into the 2021 plan year and/or from the 2021 plan year into the 2022 plan year.
2. Extend the 2020 and/or 2021 plan year grace period to 12 months with respect to unused benefits or contributions remaining in FSAs.
3. Permit employees who cease plan participation during calendar year 2020 or 2021 to continue to receive reimbursements for unused benefits or contributions remaining in FSAs until the plan year has ended.
4. Allow prospective election changes for FSAs with plan years that end in 2021 regardless of any change in status.

The new law also extends the dependent care FSA age from under 13 to under 14 for employees who enrolled in a dependent care FSA prior to January 31, 2020 and had dependents who aged out during the pandemic.

Another COVID relief bill, the American Rescue Plan Act of 2021 ("ARPA"), was signed into law on March 11, 2021. Section 9632 of ARPA provides a temporary increase to Dependent Care Assistance Plans for plan years beginning after December 31, 2020 and before January 1, 2022. The maximum contribution limit is temporarily increased from $5,000 to $10,500 for individuals who are (a) single or (b) married and filing jointly with their spouse and from $2,500 to $5,250 for individuals who are married and filing separately from their spouse.

Contact your employer to determine if these amendments were made to your plan.

FMLA EFFECT ON BENEFITS

What effect does the Family Medical Leave Act (FMLA) have on my benefits under the Plan?

An employer with 50 or more employees (for at least 20 work weeks in the current or preceding calendar year) must comply with FMLA. Basically, FMLA allows eligible employees to take up to 12 weeks (more in some states) of unpaid leave during any 12-month period:

1. For the birth or placement of a child for adoption or foster care;

2. To care for the employee's parent, spouse or child who has a serious health condition; or

3. For medical leave if the employee is unable to work because of a serious health condition.

An eligible employee is one who has:

1. Worked for the employer for a total of at least 12 months;

2. Worked at least 1,250 hours during the prior 12 months (approximately 32 hours per week); and

3. Worked at a location employing at least 50 employees of the employer within 75 miles of the worksite.

The FMLA defines a serious health condition as an illness, injury, impairment or physical or mental condition that involves either:

1. Any incapacity or treatment requiring inpatient care in a hospital, hospice, or residential medical care facility;

2. Any incapacity that requires an individual to be absent from work or other regular daily activities and that also requires treatment by a health care provider; or

3. Continuing treatment by a health care provider for a chronic or long-term condition that is incurable, or is likely to result in a period of incapacity of more than 3 calendar days.

If the employer provides group medical or dental coverage and/or health care reimbursement accounts these benefits must be continued during FMLA leave. If the employee shares the cost of health care premiums, or pays them entirely, this same arrangement also continues throughout the leave. The employer must notify the employee in writing of the terms and conditions of the premium payment in advance of the leave. Continuation of other employer-provider benefits, such as group term life insurance, short-term or long-term disability, is not required.

Unpaid FMLA leave qualifies as a Change Event allowing an employee to modify the Flexible Benefits Plan elections impacted by the change in status. An employee planning to take FMLA leave should carefully consider the impact it may have on his/her dependent care requirements in assessing the need for a modification. Other elections affected by the Change Event may also be modified.

Consult your Employer's human resource or personnel officer for specific guidance on requesting leave under FMLA.

DISCLAIMER

Because this summary is a brief description of our Plan and applicable laws, it does not include all of the terms, provisions, or limitations of the Plan or such laws. To the extent this summary is not complete, or is inconsistent with or varies from the Plan or laws, the language of the Plan or laws shall be controlling.

The tax rules described in this summary are written in general terms as of the date this summary was prepared. Also, state or local tax laws may vary and may affect you. Your individual circumstances and tax situation may also affect your decisions. Please consult state or local departments of revenue or your tax advisor regarding effects of state and local taxes, and your special circumstances.

The Employer is unable to guarantee favorable tax results from this Plan. Furthermore, the mere existence of a plan conforming to federal tax laws does not guarantee that the plan as operated will also comply with these laws. Finally, tax laws can change at any time without specific notice to you. The contents of this Summary Plan Description are not legal or tax advice to you. If you have further questions, please contact your advisors.