

**THE COLLEGE OF ST. SCHOLASTICA
FLEXIBLE SPENDING PLAN**



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Rights of *Covered Persons* under *Health FSA*

As a *covered person* in the *health FSA* portion of the *Flex Plan*, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended. With respect to the *health FSA* portion of the *Flex Plan*, *ERISA* provides that all *health FSA covered persons* shall be entitled to:

Receive Information about the *Health FSA* and Its *Benefits*

- ◆ Examine, without charge, at the *Flex Plan Administrator's* office and at other specified locations, such as work sites and union halls, all documents governing the *health FSA* portion of the *Flex Plan*, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Flex Plan* for the *health FSA* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- ◆ Obtain, upon written request to the *Flex Plan Administrator*, copies of documents governing the operation of the *health FSA* portion of the *Flex Plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The *Flex Plan Administrator* may make a reasonable charge for the copies.
- ◆ Receive a summary of the *Flex Plan* annual financial report for the *health FSA*. The *Flex Plan Administrator* is required by law to furnish you with a copy of the summary.

Continue Group Health Plan Coverage

- ◆ Continue health care coverage for *yourself* and/or *your covered dependents* under the *health FSA* portion of the *Flex Plan* if there is a loss of coverage under that portion of the *Flex Plan* as a result of a qualifying event. *You* or *your covered dependents* may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (*COBRA*) continuation coverage rights.
- ◆ Where applicable, reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the *Flex Plan*, if *you* have *creditable coverage* from another plan. *You* should be provided a certification of *creditable coverage*, free of charge, from *your* group health plan or health insurance issuer when *you* lose coverage, when *you* become entitled to elect *COBRA* continuation coverage, when *your COBRA* continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, *you* may be subject to a pre-existing condition exclusion under the *Flex Plan* for 12 months (18 months for late enrollees) after *your enrollment date*.

Prudent Actions by *Flex Plan* Fiduciaries

In addition to creating *your* rights, *ERISA* imposes duties upon the people who are responsible for the operation of the *health FSA* portion of the *Flex Plan*. “Fiduciaries” of the *Flex Plan* are the people who operate the *health FSA* portion of the *Flex Plan*, and have a duty to do so prudently, in *your* interest, in the interest of other *health FSA covered persons* and *your* 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 benefit or exercising *your* rights under *ERISA* with respect to the *health FSA* portion of the *Flex Plan*.

Enforce *Your* Rights

If *your claim* for *benefits* under the *health FSA* portion of the *Flex Plan* is denied or ignored, in whole or in part, within certain time schedules *you* have a right to:

- know why this was done;
- obtain copies of documents relating to this decision without charge; and
- appeal any denial.

Under *ERISA*, there are steps *you* can take to enforce the above rights under the *health FSA*. For instance, if *you* request a copy of the *Flex Plan* Documents or the latest annual report from the *Flex Plan* for the *health FSA* and do not receive them within 30 calendar days, *you* may file suit in a Federal court within 2 years of *your* request. In such case, the court may require the *Flex 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* under the *health FSA* that is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court within 2 years of the claim denial (if any), or if there is no claim denial within 2 years of the date of service. In addition, if *you* disagree with the *Flex Plan Administrator'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 within 2 years of the date of such order. If it should happen that *Flex Plan* fiduciaries misuse the *health FSA's* money, or if *you* are discriminated against for asserting *your* rights under the *health FSA* *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in Federal court within 2 years of the date of such event. 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 costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your claim* frivolous.

Assistance with *Your* Questions

If *you* have any questions about *your Flex Plan*, *you* should contact the *Flex Plan Administrator*. If *you* have any questions about this statement or about *your* rights under the *health FSA* under *ERISA*, or if *you* need assistance in obtaining *health FSA* documents from the *Flex Plan Administrator*, *you* should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in *your* telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. *You* may also obtain certain publications about *your* rights and responsibilities under the *health FSA* under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

Your Employer (Flex Plan Administrator)

Your employer, which also serves as the *Flex Plan Sponsor* and the *Flex Plan Administrator*, has established The College of St. Scholastica Flexible Spending Plan (the *Flex Plan*) to provide *health FSA benefits*, *dependent care FSA benefits*, *premium payment benefits* as described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Flex Plan* (the *Plan Document*). Although certain *other group benefit programs* may be paid pre-tax under the *premium payment benefit* option of the *Flex Plan*, the benefits and coverages under each of the *other group benefit programs* are described in separate materials that are distributed separately from this *Flex Plan SPD*.

The *Flex Plan* permits *covered employees* to elect *health FSA benefits* and *dependent care FSA benefits (FSA benefits)* and to pay for such *FSA benefits* with *employee contributions*. The *Flex Plan* also permits *covered employees* to elect *premium payment benefits* for purposes of payment of the *covered employee's* share of premium cost under the *employer's other group benefit programs* and to pay for such benefits with *employee contributions*. *Employee contributions* are paid on a pre-tax *salary reduction* basis. *Employee contributions* are applied by the *employer* to pay contributions for *benefits*, and for purposes of this *Flex Plan* and the Internal Revenue Code (*Code*) are considered to be *employer contributions*. The *Flex Plan* is “self-insured” which means that for *FSA benefits*, the *Flex Plan Sponsor* pays *FSA benefits* from *employer contributions* as a *claim* for *FSA benefits* and associated expenses are *incurred* and submitted for reimbursement under the *Flex Plan*, and for *premium payment benefits*, the *Flex Plan Sponsor* pays *premium payment benefits* from *employer contributions* as premiums become payable under the *employer's other group benefit programs*. *Employer* has contracted with an independent claims administrator, PreferredOne Administrative Services, Inc. (*PreferredOne*), to provide *claim* processing and other services relating to *FSA benefits* under the *Flex Plan*. However, *your employer* operates and administers its *premium payment benefits* option internally.

This *Flex Plan* is intended to qualify as a “cafeteria plan” under *Code* Section 125 and regulations thereunder. The *health FSA* portion of the *Flex Plan* is intended to qualify as a self-insured medical expense reimbursement program under *Code* Section 105, and the *dependent care FSA benefit* is intended to qualify as a dependent care assistance program under *Code* Section 129. The *premium payment benefits*, *health FSA* and *dependent care FSA benefits* are part of a single *Flex Plan* and share the same *Plan Document*. However, under the *Code* and the Employee Retirement Income Security Act of 1974 (*ERISA*), different disclosure, reporting, non-discrimination, applicable *COBRA* continuation coverage and *covered person's* rights apply to each *benefit* type.

The *health FSA benefit* portion of the *Flex Plan* and the *employer's other group benefit programs* for which premiums are paid under this *Flex Plan* are subject to *ERISA* while the *dependent care FSA benefit* is not subject to *ERISA*. As a result, certain provisions of the *Flex Plan Plan Document* and *SPD*, such as the “Rights of Covered Persons” section, are applicable only to the *health FSA* portion of the *Flex Plan*, as required by *ERISA* laws. Such provisions are noted in the *Flex Plan Plan Document* and this *SPD*. The provisions of the *Flex Plan Plan Document* and *SPD* applicable to the *health FSA* are intended to comply with *ERISA*, as amended.

The *Flex Plan Administrator* in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this *Flex Plan* is established and maintained. The *Flex Plan Administrator* has the exclusive and final discretionary authority to revise the method of accounting for the *Flex Plan*, establish rules, and prescribe any forms required for administration of the *Flex Plan*. All determinations and decisions made by or on behalf of the *Flex Plan Administrator* will be final and binding on the *Flex Plan*, all persons covered by the *Flex Plan*, all persons or entities requesting payment, reimbursement or a *claim* for *benefits* under the *Flex Plan* and all interested parties. The *Flex Plan Administrator* retains all fiduciary

responsibilities with respect to the *Flex Plan*, has the exclusive and final binding discretionary authority to interpret and administer the *Flex Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Flex Plan Administrator* has expressly delegated to other individuals or entities one or more fiduciary responsibilities with respect to the *Flex Plan*.

The *Flex Plan Sponsor*, by action of its governing body or an authorized officer or *committee*, reserves the right to amend or terminate the *Flex Plan*. This includes, but is not limited to, changes to contributions, *benefits* payable and any other terms or conditions of the *Flex Plan*. The decision to amend the *Flex Plan* may be due to changes in federal laws governing employee benefits, or for any other reason. The *Flex Plan* may be changed to transfer the *Flex Plan's* liabilities to another plan or split this *Flex Plan* into two or more parts.

The *Flex Plan Administrator* has the power to delegate specific duties and responsibilities. Any reference in the *SPD* to the *Flex Plan Administrator* is also a reference to its delegated designee. Any delegation by the *Flex Plan Administrator* may allow further delegations by such individuals or entities to whom the delegation has been made. The *Flex Plan Administrator* may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated, shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

PreferredOne Administrative Services, Inc. (*PreferredOne*, TPA)

PreferredOne, as an external administrator referred to as a *third party administrator (TPA)*, provides certain administrative services, including *claim* processing services, and complaint resolution assistance with respect to *FSA benefits* under this *Flex Plan*. *PreferredOne* does not provide administrative services with respect to, and is not an administrator or insurer of the *premium payment benefits* option of the *Flex Plan*, or *other group benefit programs* except where *PreferredOne* is the contract administrator of the *employer's* self-insured group medical plan.

Article I. Introduction to *Your* Coverage

Summary Plan Description (SPD)

This *Summary Plan Description (SPD)* is *your* description of the *Flex Plan Sponsor's* Flexible Spending Plan (the "*Flex Plan*"). Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give *you* incomplete information regarding *your* rights and responsibilities under the *Flex Plan*. The *SPD* describes the *Flex Plan's* *benefits* and limitations for *your* *Flex Plan* coverage. Included in this *SPD* is a description of *your* *premium payment benefits* and *FSA benefits* that states the amount payable and reimbursable for the covered expenses. *Benefits* are not provided for excluded expenses, as determined by the *Flex Plan Administrator* or its designee. A provider recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a covered expense. *Benefits* are not available for *medically necessary* services, unless such services are also covered expenses. The *Flex Plan Administrator* has the sole, final and exclusive discretion to determine *benefits* available under the *Flex Plan*.

Italicized words used in this *SPD* have special meanings and are defined at the back of this *SPD*. *You* should keep *your* *SPD* in a safe place for *your* future reference. Amendments that are included with this *SPD* or adopted by the *Flex Plan Sponsor* are fully made a part of this *SPD*.

The *SPD* provisions for the *health FSA* are intended to comply with *ERISA*, as amended. This *Flex Plan* is maintained exclusively for *you*. *Your* rights under the *health FSA* portion of the *Flex Plan* are legally enforceable under *ERISA*.

Administrative Services Agreement

The signed Health Services Network Access and Administration Agreement, along with the Group Flexible Spending Account Administration Addendum, between *your employer* and the *TPA* constitutes the entire agreement between *your employer* and the *TPA* relating to the *TPA's* administration of the flexible spending accounts (*FSAs*) under this *Flex Plan*. A version of such agreement is available for inspection from *your employer*.

Governing Law and Conflict with Existing Law

The *Flex Plan* Plan Document and *SPD* shall be construed, administered and enforced according to the laws of the State of Minnesota, except to the extent superceded by the *Code*, *ERISA* (where applicable) or any other federal law. If any provision of this *SPD* conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

Privacy

This *Flex Plan* is subject to the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rules. In accordance with the HIPAA Privacy Rules, the *Flex Plan* and the *TPA* acting on the *Flex Plan's* behalf, maintains, uses, or discloses *your* Protected Health Information for things like claims processing, utilization review, quality assessment, case management, and otherwise as necessary to administer the *Flex Plan*. *You* can obtain a copy of the *Flex Plan's* Notice of Privacy Practices (which summarizes the *Flex Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how the *Flex Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Flex Plan Administrator*.

Clerical Error

If a clerical error or other mistake occurs, that error does not deprive *you* of coverage for which *you* are otherwise eligible nor does it give *you* coverage under the *Flex Plan* for which *you* are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or *benefit* coverage. Determination of *your* coverage will be made at the time the *claim* is reviewed. It is *your* responsibility to confirm the accuracy of statements made by the *Flex Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and the Plan Documents. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination.

Article II. Eligibility, Enrollment and Participation, Termination and Leaves

A. Eligibility

Premium Payment Benefits:

To enroll for *premium payment benefits* *you* must be classified by the *Flex Plan Sponsor* as a regular employee and enrolled for coverage in the applicable *group benefit program* of the *employer*.

FSA Benefit:

To be eligible to enroll for *health FSA benefits* and *dependent care FSA benefits* you must be classified by the *Flex Plan Sponsor* as a full-time common law employee in one of the classifications described below:

- a. Faculty Employees regularly scheduled to work a minimum of 25 hours per week; or
- b. Administration and Support Employees regularly scheduled to work a minimum of 30 hours per week; or
- c. Union Employees regularly scheduled to work a minimum of 40 hours per week.

For purposes of all *benefit* options under this *Flex Plan*, the following classifications of workers, as determined by the *employer*, are not eligible to enroll for coverage, as determined by the *Flex Plan Administrator*:

1. Temporary or leased employees;
2. Independent contractors who sign an agreement with Employer as an independent contractor;
3. Consultants who are paid other than a regular wage or salary by the *employer*;
4. Members of the *employer's* board of directors; and
5. Owners, partners, or officers of the *employer* unless engaged in the conduct of the *employer's* business on a full-time regular basis.

For purposes of all *benefit* options under this *Flex Plan* the term “employee” shall not include a self-employed individual, a partner in a partnership, a sole proprietor, and a more than 2% shareholder in a Subchapter-S corporation.

The *employer's* classification of an employee is conclusive and binding for purposes of determining eligibility under this *Flex Plan*. No reclassification of an employee's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the *employer* agrees to such reclassification, shall change a person's eligibility for *benefits*.

B. Enrollment and Participation

New Enrollment for *Premium Payment Benefits*. *You* are automatically enrolled for pre-tax *premium payment benefits* at the same time *you* are enrolled for coverage under the *employer's* applicable *group benefit program*. *You* may opt out of the pre-tax *premium payment benefits* and have applicable premiums paid and deducted from *your* pay on an after-tax basis by contacting the *Flex Plan Administrator* upon enrollment for the applicable *group benefit program*. Once *you* are automatically enrolled or *you* opt out *your* election is effective for the *plan year*, unless *you* qualify for an election change event.

New Enrollment for *FSA Benefits*. *You* must submit written or online application (as designated by the *Flex Plan Administrator*) to the *Flex Plan Administrator* to enroll *yourself*, elect *FSA benefits* and agree to *salary reduction* for required contributions for elected *FSA benefits*, within 30 calendar days of *your* first day of employment. *Your* participation will take effect as follows, provided *you* timely submitted the *FSA election form/salary reduction agreement* to the *Flex Plan Administrator*:

Faculty, Administration, and Support Employees: *You* become eligible to participate on the first day of the month following *your* first day of employment. *Your* participation becomes effective on the first day of the month after *you* completed *FSA election form/salary reduction agreement* is received by the *Flex Plan Administrator*.

Union Employees: *You become eligible to participate on the first day of the month following a 60-day waiting period. If your waiting period ends on the first day of the month, your coverage will not become effective until the first day of the following month. Your participation becomes effective on the first day of the month after you satisfy the waiting period provided that your completed FSA election form/salary reduction agreement was timely submitted to the Flex Plan Administrator.*

Annual Enrollment. Subject to all eligibility, enrollment and any pre-existing condition limitations, you may enroll and elect *premium payment benefits*, and *FSA benefits* during the *employer's annual enrollment period* and your participation will take effect on the first day of the next *plan year* or, in the case of *premium payment benefits*, the effective date of your applicable *group benefit program* coverage. To enroll for *FSA benefits* at annual enrollment you must submit the *FSA election form/salary reduction agreement* to the *Flex Plan Administrator* within the *employer's annual enrollment period* and before the first day of the next *plan year*.

Late Enrollment Due to Election Change Events. If you do not submit your completed *FSA election form/salary reduction agreement* to the *Flex Plan Administrator* within 30 calendar days of your first day of employment or at annual enrollment, you may enroll and elect *premium payment benefits* and *FSA benefits* thereafter only in accordance with the procedures for mid-year changes under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)."

Irrevocability of Enrollment Elections. Regardless of when you enroll, your enrollment elections under the *Flex Plan*, including your *salary reduction* amount, your participation in these *Flex Plan benefit* elections, and election of a particular *benefit package option* under a *group benefit program* are irrevocable for the duration of the *period of coverage* to which your election relates, except as provided in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)."

Special Enrollment Events for Premium Payment Benefits under Group Health Programs. If you change your group health coverages under the *employer's group benefit program* as a result of a special enrollment event described in the group health certificate or summary plan description, your *premium payment benefits* under this *Flex Plan* will automatically change to reflect such event. If you, your spouse or dependent enroll in the *employer's group health program* due to special enrollment, you will be enrolled to pay for such coverage (or additional coverage) on a pre-tax basis under the *premium payment benefits* option of the *Flex Plan*.

C. Termination and Leaves

1. **Termination of Participation and Elections.** A *covered employee* will cease to be a *covered employee* and cease *salary reduction elections* and participation in this *Flex Plan* and all applicable *premium payment benefits* and *FSA benefits* upon the earlier of:
 - a. the expiration of the *period of coverage* for which the *covered employee* has elected to participate (unless during the *employer's annual enrollment period* for the next *plan year* the *covered employee* elects to continue participating);
 - b. the termination of this *Flex Plan*;
 - c. the date on which the employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be a *covered employee* or an employee, provided that eligibility may continue beyond such date for purposes of pre-taxing *health FSA COBRA* coverage for former employees receiving severance or other taxable *compensation*, as may be permitted by the *Flex Plan Administrator* on a uniform and consistent basis (but not beyond the end of the current *plan year*) under the Article entitled, "*Health FSA Benefits*";

- d. the date on which the *covered employee* revokes his or her election to participate in the *Flex Plan* under a circumstance when such change is permitted under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)";
- e. The date on which the *covered employee* fails to pay the required contribution for elected *benefits*;
- f. The date on which the employee ceases to be eligible for the *Flex Plan*; or
- g. For *premium payment benefits* only: the date on which the employee ceases to be eligible for the applicable *group benefit program*.

Reimbursements from the *health FSA benefit* and *dependent care FSA benefit* after termination of participation will be made pursuant to the Article entitled, "*Health FSA Benefits*" and the Article entitled, "*Dependent Care FSA Benefit*", as applicable.

2. **Re-enrollment and Participation after Termination of Employment or Loss of Eligibility.** If a *covered employee's* employment terminates for any reason, and then he/she is re-employed within 30 calendar days of, and in the same *plan year* as, the date of termination of employment and is otherwise eligible to participate in the *Flex Plan*, the employee will be automatically reinstated as a participant in the *Flex Plan* with the same elections (including *salary reduction* elections) that such individual had immediately before termination. This is required by the federal regulations governing flex benefit plans. The reinstatement of *your salary reduction* election will not reinstate *your* coverage for group medical, dental or other benefits under the *group benefit programs*. Such coverage may be reinstated only if permitted under such programs. A *covered employee* will only be allowed to change *salary reduction* elections including *premium payment benefits* if he or she experience or have experienced an election change event (other than termination and commencement of employment) as described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)." If a former *covered employee* is re-employed more than 30 calendar days after the date of termination of employment, or is re-employed in a subsequent *plan year*, and is otherwise eligible to participate in the *Flex Plan*, then the individual may make new elections as a new hire. If an employee (whether or not a *covered employee*) ceases to be an eligible employee for any reason (other than for termination of employment), including, but not limited to, a reduction in hours or change in employee classification, and then becomes an eligible employee again, the employee must complete the waiting period before again becoming eligible to participate in the *Flex Plan*.

3. **FMLA Leaves of Absence.**

- a. **Premium Payment for Medical Group Benefit Programs and Health FSA Benefits.** Notwithstanding any provision to the contrary in this *Flex Plan*, if a *covered employee* goes on a qualifying leave under the *FMLA*, then to the extent required by the *FMLA*, the *employer* will continue to maintain the *covered employee's* medical *group benefit programs* and *health FSA benefits* on the same terms and conditions as if the *covered employee* were still an active employee. That is, if the *covered employee* elects to continue his or her coverage while on *FMLA* leave, the *employer* will continue to pay its share (if any) of the medical *group benefit programs premiums* and *health FSA* premiums contribution. An *employer* may elect to require continued medical *group benefit program* premiums and *health FSA benefits* for *covered employees* while they are on paid *FMLA* leave (provided *covered employees* on non-*FMLA* paid leave are also required to continue coverage). If so, the *covered employee's* share of the medical *group benefit program* premiums, and *health FSA* contribution shall be paid by the method normally used during any paid leave (e.g., on a pre-tax *salary reduction* basis if that was the method used during a non-*FMLA* leave.)

In the event of unpaid *FMLA* leave (or paid *FMLA* leave where coverage is not required to be continued), a *covered employee* may elect to continue his or her medical *group benefit program* premiums and *health FSA benefits* during the leave. If the *covered employee* elects to continue coverage while on unpaid *FMLA* leave, then the *covered employee* may pay his or her share of the premium in one of the following ways:

- (1) with after-tax dollars, by sending monthly payments to the *employer* by the due date established by the *employer*;
- (2) with pre-tax dollars, by having such amounts regularly withheld from the *covered employee's* ongoing *compensation* (if any, including unused sick days, *employer* paid disability and vacation days), or pre-paying all or a portion of the contribution for the expected duration of the leave on a pre-tax *salary reduction* basis out of pre-leave *compensation*. To pre-pay, the *covered employee* must make a special election prior to the date that such *compensation* would normally be made available (and pre-tax dollars may not be used to fund coverage or *benefits* during the next *plan year*); or
- (3) under another arrangement agreed upon between the *covered employee* and the *Flex Plan Administrator* (e.g., the *Flex Plan Administrator* may fund coverage during the leave and withhold "catch-up" amounts from the *covered employee's compensation* upon the *covered employee's* return from leave on a pre-tax or after-tax basis).

If the *employer* requires all *covered employees* to continue medical *group benefit programs* and *health FSA benefits* during an unpaid *FMLA* leave, the *covered employee* may elect to discontinue payment of the *covered employee's* required contributions until the *covered employee* returns from leave. Upon returning from leave, the *covered employee(s)* will be required to repay contributions not paid by the *covered employee* during the leave. Such "catch-up" payments shall be withheld from the *covered employee's compensation* either on a pre-tax or after-tax basis, as may be agreed upon by the *Flex Plan Administrator* and the *covered employee*.

If a *covered employee's* medical *group benefit programs* and *health FSA benefits* terminate while on *FMLA* leave (e.g., for non-payment of required contributions), the *covered employee* is entitled to re-enroll and participate in the medical *group benefit programs* and *health FSA benefits* (as applicable) upon return from leave on the same basis as the *covered employee* was participating in the *Flex Plan* prior to the leave, or as otherwise required by the *FMLA*. *Covered employees* whose medical *group benefit programs* or *health FSA benefits* terminated during the *FMLA* leave are entitled to be automatically reinstated provided that medical *group benefit programs* and *health FSA benefits* for employees on non-*FMLA* leave are also automatically reinstated upon return from leave. Notwithstanding the preceding sentence, with *health FSA benefits*, a *covered employee* whose *benefits* ceased will be entitled to elect whether to be reinstated in *health FSA benefits* at the same benefit level as in effect before the *FMLA* leave (with increased contributions for the remaining *period of coverage*) or at a *benefit* level that is reduced pro-rata for the period of *FMLA* leave during which the *covered employee* did not pay contributions. If a *covered employee* elects a *benefit* level that is reduced pro-rata for the period of *FMLA* leave, the amount withheld from a *covered employee's compensation* on a payroll-by-payroll basis for the purpose of paying for reinstated *health FSA benefits* will be equal to the amount withheld prior to the period of *FMLA* leave.

- b. **Non-Health Benefits.** If a *covered employee* goes on a qualifying leave under the *FMLA*, entitlement to non-health *benefits* (such as, where applicable, *premium payment benefits* for group term life or disability benefits or *dependent care FSA benefits*), is to be determined by the *employer's* policy for providing such *benefits* when the *covered employee* is on non-*FMLA* leave, as described in item 4. below. If such policy permits a *covered employee* to discontinue contributions while on leave, the *covered employee* will upon returning from leave be required to repay the

contributions not paid by the *covered employee* during the leave. Payment shall be withheld from the *covered employee's compensation* upon return from leave either on a pre-tax or after-tax basis, as may be agreed upon by the *Flex Plan Administrator* and the *covered employee* or as the *Flex Plan Administrator* otherwise deems appropriate.

4. **Non-FMLA Leaves of Absence.** If a *covered employee* goes on an unpaid leave of absence that does not affect eligibility, then the *covered employee* will continue to participate and the premium due for the *covered employee* 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 *Flex Plan Administrator*. If a *covered employee* goes on an unpaid leave that affects eligibility, the election change rules in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", C. will apply.

Article III. Benefits Offered, Contributions and Flex Plan Payments

A. Benefits Offered

When first eligible or during the *annual enrollment period* as described under the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves, *covered employees* will be given the opportunity to elect one or more of the following *benefits*:

1. *Health FSA benefits*, as described in the Article entitled, "*Health FSA Benefits*";
2. *Dependent care FSA benefits*, as described in the Article entitled, "*Dependent Care FSA Benefit*"; and
3. *Premium payment benefits* as described in the Article entitled, "*Premium Payment Benefits*".

In no event shall *benefits* under the *Flex Plan* be provided in the form of deferred *compensation*.

B. Contributions

1. **Employee Contributions.** The *employer* shall withhold from a *covered employee's compensation* on a pre-tax *salary reduction* basis (or with after-tax deductions as elected by the *covered employee* and permitted under the *Flex Plan*) an amount equal to the contributions required from the *covered employee* for the *benefits* he/she elected under this *Flex Plan*. Amounts withheld or deducted from a *covered employee's compensation* shall be applied to pay *benefits* as soon as administratively feasible. The maximum amount of *salary reductions* (or after-tax deductions, as applicable) for the *benefit* of each *covered employee* shall not exceed the aggregate cost of the *benefits* elected. *Covered employees* who elect any of the *FSA benefits* shall pay for their required contributions, if any, on a pre-tax *salary reduction* basis. For *FSA benefits*, the *covered employee* must complete an *election form/salary reduction agreement* supplied by the *Flex Plan Administrator*.
 - a. **Salary Reductions per Pay Period.** The *salary reduction* for a pay period for a *covered employee* is, for the *benefits* elected, an amount equal to (1) (a) the annual contributions for such *benefits* (as described in the Article entitled, "*Health FSA Benefit*", the Article entitled, "*Dependent Care FSA Benefit*", and the Article entitled, "*Premium Payment Benefits*", as applicable), divided by (b) the number of pay periods from which *salary reduction* is taken in the *period of coverage*; (2) an amount otherwise agreed upon between the *employer* and the *covered employee*; or (3) an amount deemed appropriate by the *Flex Plan Administrator* (i.e., in the event of shortage in reducible *compensation*, amounts withheld may fluctuate). If a *covered employee* who is making *salary reductions* increases his or her election for *health FSA benefits* or *dependent care FSA benefits* as permitted under the Article entitled, "Election Change Events (Exceptions to Irrevocable

Elections)", his/her *salary reductions* per applicable pay period will be, for the *benefits* affected, an amount equal to (1) (a) the new reimbursement limit elected less the aggregate contributions for the period prior to such election change, divided by (b) the number of applicable pay periods remaining in the *period of coverage* commencing with the election change; (2) an amount otherwise agreed upon between the *employer* and the *covered employee*; or (3) an amount deemed appropriate by the *Flex Plan Administrator* (i.e., in the event of shortage of reducible *compensation*, amounts withheld may fluctuate).

- b. **Considered *Employer Contributions for Certain Purposes*.** *Salary reductions* are applied by the *employer* to pay for the *covered employee's* share of the contributions for *premium payment benefits, health FSA benefits, and dependent care FSA benefits* and, for purposes of this *Flex Plan* and the *Code*, are considered to be *employer contributions*.
- c. **After-Tax Contributions for *Premium Payment Benefits*.** For those *covered employees* who elect to pay their share of the cost of any of the *premium payment benefits* with after-tax deductions, both the *covered employee* and *employer* portions of such contributions will be paid outside of this *Flex Plan*.

C. *Flex Plan Payments*

All of the amounts payable under this *Flex Plan* shall be paid from the general assets of the *Flex Plan Sponsor*, except that *premium payment benefits* and *benefits* paid under any insured or HMO *group benefit program* will be paid in accordance with the applicable insurance policy or certificate of coverage. No *covered employee* or other person shall have any *claim* against, right to, or security or other interest in any fund, *Account* or asset of the *Flex Plan Sponsor* or *Flex Plan Administrator* from which any payment under this *Flex Plan* may be made. There is no trust or other fund from which *Flex Plan benefits* are paid. The maximum contributions that may be made under this *Flex Plan* for a *covered employee* is the total of the maximums that may be elected as *employee contributions* for *premium payment benefits* plus maximums elected under the sections for *health FSA benefits* and *dependent care FSA benefits*.

Article IV. *Health FSA Benefits*

A. *Health FSA Benefits*

An eligible employee can participate in the *health FSA* by enrolling and electing to receive *benefits* in the form of reimbursements for medical care expenses (*health FSA benefits*). *Benefits* elected will be paid by *employee contributions*. Unless an exception applies (as described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", such election is irrevocable for the duration of the *period of coverage* to which it relates.

B. *Health FSA Benefits Contributions for Cost of Coverage*

The annual contribution for a *covered employee's health FSA benefits* is equal to the annual *benefits* amount elected by the *covered employee* (for example, if the maximum \$5,000 annual *benefits* amount is elected, then the annual contribution amount is also \$5,000).

C. Eligible *Medical Care Expenses* (a.k.a. Covered Expenses)

Under the *health FSA* a *covered employee* may receive reimbursement only for *medical care expenses incurred* during the *period of coverage* for which an election is in force. Certain *covered employees* may receive reimbursement for *medical care expenses* incurred during the *grace period* that immediately follows the close of a *plan year* from amounts (if any) remaining in a *covered employee's health FSA account* for that *plan year* in accordance with Article IV.D.5, "*Grace Periods; Rules for Expenses Incurred during a Grace Period*," as amended. A *medical care expense* is *incurred* at the time the medical care or service giving rise to the expense is furnished, and not when the *covered employee* is formally billed, charged, or pays for the medical care.

For purposes of this option, "*medical care expenses*" means expenses *incurred* by a *covered employee* or his or her *spouse* or *dependents* for medical care, as defined in *Code* Section 213 (d) (including, for example, amounts for certain hospital bills, doctor and dental bills, prescription drugs and certain over-the-counter medications), other than expenses that are excluded under the Article entitled, "*Exclusions*" of this *Flex Plan*, but only to the extent that the *covered employee* or other person *incurring* the expense is not reimbursed (nor is the expense reimbursable) through any insurance plan, other insurance, or any other accident or medical plan. If only a portion of a *medical care expense* is reimbursed or reimbursable elsewhere (e.g., because the medical insurance plan imposes co-payment or deductible limitations), the *general-purpose health FSA option* can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article entitled, "*Health FSA Benefits*."

Special Rule if Also Enrolled under *Employer's Health Reimbursement Arrangement (HRA) Program*. If the *covered person* is also enrolled for coverage or participation under a health reimbursement arrangement (HRA) program sponsored by the *employer* and a *medical care expense* is eligible for reimbursement under *your* HRA account and this *health FSA Account*, such expense will be processed (approved/denied for reimbursement) as follows: (1) if the *covered person* or his or her provider first submits it under the HRA program, it will be processed first by the HRA program administrator and, if there is a remaining portion, the *covered person* may then submit it on the written *health FSA* reimbursement claim form under this *health FSA benefits program*; or (2) if the *covered person* first submits it under this *health FSA benefits program*, it will be processed first under this *health FSA* program and if there is a remaining portion, the *covered person* may then submit it under the HRA program.

To obtain general information about "*medical care expenses*", refer to IRS Publication 502 on deductible *medical care expenses*, however, even if deductible under IRS Publication 502, the *medical care expenses* will not be reimbursable under this *Flex Plan* if listed as an exclusion under the Article entitled, "*Exclusions*".

D. Maximum Benefits

1. **Maximum Reimbursement Benefits Available; Uniform Coverage.** The maximum dollar amount elected by the *covered employee* for reimbursement of *medical care expenses incurred* during a *period of coverage* (reduced by prior reimbursements during the same *period of coverage*) shall be available at all times during the *period of coverage*, regardless of the actual amounts credited to the *covered employee's health FSA account* pursuant to the "Establishment of Account" section. Notwithstanding the foregoing, no reimbursements will be available for *medical care expenses incurred* after coverage under this *Flex Plan* has terminated, unless the *covered employee* has elected *COBRA* as provided in Article IV.G.5, "*Reimbursements after Termination; COBRA*," or is entitled to submit expenses *incurred* during a *grace period* as provided in Article IV.D.5, "*Grace Periods; Rules for Expenses Incurred during a Grace Period*." Reimbursement and payment shall

be made to the *covered employee* in the form of a check drawn on a bank account, or, if elected by the *covered employee*, by direct deposit to the *covered employee's* designated bank account, as reimbursement for *medical care expenses incurred* during the *period of coverage* for which the *covered employee's* election is effective (or during a *grace period*, if applicable under Article IV.D.5., "*Grace Periods; Rules for Expenses Incurred during a Grace Period*"), provided that the other requirements of this Article IV are met.

2. **Maximum Dollar Limits.** The maximum annual *benefit* amount that a *covered employee* may elect to receive under this *Flex Plan* in the form of reimbursements for *medical care expenses incurred* in any *period of coverage* shall be \$5,000. Reimbursements for *medical care expenses incurred* by the *covered employee's spouse* or *dependents* shall be charged against the *covered employee's health FSA account*.
3. **Changes: No Proration.** For *plan years* that begin after the effective date, the maximum dollar limit may be changed by the *Flex Plan Administrator* and shall be communicated to eligible employees through the *election form/salary reduction agreement* or another document. If a *covered employee* enrolls for the *health FSA benefits* mid-year, or increases his or her election mid-year as permitted under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", there will be no proration of the dollar limit (i.e., the *covered employee* may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable).
4. **Effect on Maximum Reimbursement *Benefits* if Election is Changed.** Any change in an election under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", affecting annual contributions to the *health FSA* also will change the maximum reimbursement *benefits* for the remainder of the *period of coverage* commencing with the election change. Such maximum reimbursement *benefits* for the remainder of the *period of coverage* shall be calculated by adding (1) the aggregate contribution to the *health FSA* for the period prior to such election change to (2) the total contribution to the *health FSA* for the remainder of such *period of coverage*, reduced by (3) all prior reimbursements made during the entire *period of coverage*.
5. ***Grace Periods; Rules for Expenses Incurred during a Grace Period.*** Notwithstanding any contrary provision in this *SPD* and subject to the conditions of Article IV.D.2., "Maximum Dollar Limits," a *covered employee* may be reimbursed for *medical care expenses incurred* during a *grace period* from amounts remaining in his/her *health FSA account* at the end of the *plan year* to which that *grace period* relates ("*prior plan year health FSA amounts*") provided that s/he is (1) a *covered employee* with *health FSA benefits* in effect on the last day of such *plan year*; or (2) a qualified beneficiary, as defined by *COBRA*, who has *COBRA* continuation coverage in effect for *health FSA benefits* on the last day of such *plan year*; and (3) further provided that s/he manually (non-electronically) submits a written request for reimbursement using the *Flex Plan Administrator's* approved reimbursement form for *grace period* expenses. The following additional rules apply to *grace periods* and *medical care expenses incurred* during a *grace period*: (1) *prior plan year health FSA amounts* may not be cashed out, converted to other taxable or nontaxable benefits or applied toward *dependent care expenses*; (2) *medical care expenses incurred* during a *grace period* and approved for reimbursement under the *Flex Plan* will be reimbursed first from available *prior plan year health FSA amounts* and thereafter from any amounts available under the *health FSA account* for the current *plan year*; (3) a *covered employee's prior plan year health FSA amounts* will be debited for reimbursements of *medical care expenses incurred* during the *grace period* that are reimbursed from such prior plan year *health FSA amounts*; (4) requests for reimbursement of *medical care expenses incurred* during a *grace period* must be submitted by the last day of the fourth calendar month (April 30) following the end of the *plan year* to which the *grace period*

relates to be reimbursed from *prior plan year health FSA amounts*; and (5) *prior plan year health FSA amounts* that remain after all reimbursements have been made for the *plan year* including any associated *grace period* can not be carried over to reimburse expenses *incurred* in any subsequent period and shall be forfeited in accordance with Article IV.F., "Forfeiture of *Accounts*; Use-It-Or-Lose-It Rule."

E. Establishment of *Account*

The *Flex Plan Administrator* will establish a *health FSA account* with respect to each *covered employee* who participates in the *health FSA benefit* but will not create a separate fund or otherwise segregate assets for this purpose. The *account* so established will merely be a recordkeeping *account* for purposes of tracking contributions and determining forfeitures.

1. **Crediting of *Accounts*.** A *covered employee's health FSA account* will be credited periodically during each *period of coverage* in an amount equal to the *covered employee's salary reductions* allocable to such *account*.
2. **Debiting of *Accounts*.** A *covered employee's health FSA account* will be debited during each *period of coverage* (or during any *grace period*, if applicable under Article IV.D.5., "*Grace Periods*; Rules for Expenses *Incurred* during a *Grace Period*.")) for any reimbursement of *medical care expenses incurred* during the *period of coverage* (or during any *grace period*, if applicable under Article IV.D.5., "*Grace Periods*; Rules for Expenses *Incurred* during a *Grace Period*.")) The amount available for reimbursement *benefits* is described in the Article entitled, "*Health FSA Benefits*", D. above.

F. Forfeiture of *Accounts*; Use-It-Or-Lose-It Rule

Except as otherwise provided in Article IV.D.5 regarding *grace periods*, if any balance remains in the *covered employee's health FSA account* for a *period of coverage* after all reimbursement *benefits* have been made for such period, the balance shall not be carried over to reimburse the *covered employee* for *medical care expenses incurred* during a subsequent *plan year*. As required by the *Code*, the *covered employee* shall forfeit all rights with respect to such balance. All forfeitures under this *Flex Plan* shall be used as follows: first, to reduce the cost of administering this *Flex Plan* during the *plan year* or subsequent *plan years*, and second, to provide increased *benefits* or compensation to *covered employees* in subsequent years as the *Flex Plan Administrator* deems appropriate, consistent with applicable laws and regulations. In addition, any *health FSA benefit* payments that are unclaimed (e.g., uncashed benefit checks) by the end of the *plan year* after the *period of coverage* in which the *health FSA expense* was *incurred*, shall be forfeited and applied as described above.

G. Reimbursements and Initial Benefit Determination of Post-Service *Claims*

1. **Post-Service *Claims*.** Post-service *claims* are *claims* that are filed for payment and reimbursement of *benefits* under the *Flex Plan* after *medical care expenses* or *dependent care expenses* (as applicable) have been *incurred* and submitted in accordance with the post-service *claim* substantiation and filing procedures for the *Flex Plan*.
2. **Substantiation and Filing Procedures for Post-Service *Claims*.** A *covered employee* who has elected to receive *health FSA benefits* may apply for reimbursement by submitting a complete written *claim* request for reimbursement to the *TPA* at the address noted inside the cover page of this *SPD*, by no later than the last day of the fourth calendar month following the close of the *plan year* (a) in which the *medical care expense* was *incurred*, or (b) to which the *grace period* relates for

medical care expenses incurred during a grace period, and setting forth the following essential data elements:

- a. the person or persons on whose behalf *medical care expenses* have been *incurred*;
- b. the nature and date of the expenses so *incurred*;
- c. the amount of the requested reimbursement; and
- d. a statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The reimbursement claim must be accompanied by bills, invoices, or other written statements from an independent third party showing that the *medical care expenses* have been *incurred* and the amounts of such expenses, together with any additional documentation that the *TPA* may request or the *Flex Plan Administrator* may require. Except for the final reimbursement *claim* for a *period of coverage*, no *claim* for reimbursement may be made unless and until the aggregate *claims* for reimbursement is at least \$25. If *you* have not submitted the post-service *claim* in accordance with these procedures, including a failure to submit all essential data elements, *your* post-service *claim* will be treated as incorrectly filed. Please note that the time periods (below) for making an initial benefit determination begin when the *TPA* receives a written post-service *claim* submitted in accordance with the *Flex Plan's* filing procedures.

3. **Timing of Initial Benefit Determination.** Within 30 calendar days after receipt of a properly filed reimbursement *claim* from a *covered employee*, the *Flex Plan* will reimburse the *covered employee* for the *covered employee's* *medical care expenses*, or the *covered employee* will be notified that his or her *claim* has been denied. If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Flex Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial benefit determination, it may extend the time period for the initial benefit determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 30-calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial benefit determination within 15 calendar days after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied.

The time period for the initial benefit determination may also be extended for 15 calendar days for circumstances beyond the *TPA's* control.

If *your* post-service *claim* is denied, written notification will be provided to *you*. This notice will explain:

- a. the reason for the denial;
 - b. the part of the *Flex Plan* on which it is based;
 - c. any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
 - d. the procedure for requesting an appeal.
4. **Claims Denied.** To appeal denied *claims* for *health FSA* benefit reimbursement, refer to the appeals procedure in the Article entitled, "Appeals Procedure".
 5. **Claims Ordering; No Reprocessing.** *Claims* for reimbursement from a *covered employee's* *health FSA benefit* will be paid in the order in which they are processed and approved under the *Flex Plan*.

Once paid, a *claim* will not be reprocessed or recharacterized solely for the purpose of paying it or treating it as paid from amounts attributable to another *plan year* or *period of coverage*.

H. Reimbursements after Termination; *COBRA*

When a *covered employee* ceases to be a *covered employee* and participation terminates under this *Flex Plan*, the *covered employee's salary reductions* and election to receive reimbursements will automatically terminate. Except as otherwise provided in Article IV.D.5 (regarding any *grace period*), the *covered employee* will not be able to receive reimbursements for *medical care expenses incurred* after participation terminates. However, such *covered employee* (or the *covered employee's estate*) may claim reimbursement for *medical care expenses incurred* during the *period of coverage* prior to termination of participation (or during any *grace period* to which s/he is entitled pursuant to Article IV.D.5, "*Grace Periods; Rules for Expenses Incurred during a Grace Period*", provided that the *covered employee* (or such estate) files a *claim* by the last day of the fourth calendar month following the close of the *plan year* in which the *covered employee* ceased to be enrolled for *health FSA benefits* and ceased participation under the *Flex Plan*.

Notwithstanding any provision to the contrary, to the extent required by *COBRA*, a *covered employee* and his or her *spouse* and *dependents*, whose coverage terminates under the *health FSA* because of a *COBRA* qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the *health FSA* the day before the qualifying event for the periods prescribed by *COBRA*, with the entire contribution cost for such continuation coverage to be paid by such individual(s) on an after-tax basis, unless permitted otherwise by the *Flex Plan Administrator* on a uniform and consistent basis (but not beyond the current *plan year*). Such individual(s) will be eligible for *COBRA* continuation coverage only if, they have a positive *health FSA account* balance at the time of a *COBRA* qualifying event (taking into account all *claims* submitted on or before the date of the qualifying event). Such individuals will be notified if they are eligible for *COBRA* continuation coverage. If *COBRA* is elected, it will be available only for the remainder of the *plan year* in which the qualifying event occurs; such *COBRA* coverage for the *health FSA* will cease at the end of such *plan year* and cannot be continued for the next *plan year*.

Notwithstanding the foregoing, a qualified beneficiary, as defined by *COBRA*, who is enrolled for *COBRA* continuation under the *health FSA benefit* on the last day of the *plan year* may be entitled to reimbursement of *medical care expenses incurred* during the *grace period* following such *plan year* in accordance with Article IV.D.5., "*Grace Periods; Rules for Expense Incurred during a Grace Period.*"

I. Compliance with *ERISA*, *COBRA*, *HIPAA* Privacy, Etc.

1. **Laws Applicable to Group Health Plans.** *Health FSA benefits* shall be provided in compliance with *ERISA*, *COBRA*, and *HIPAA* privacy laws otherwise applicable to *health FSA* type self-insured group health welfare benefit plans.
2. **Coordination of Benefits.** *Health FSA benefits* are intended to pay *benefits* solely for *medical care expenses* not previously reimbursed or reimbursable elsewhere. Accordingly, the *health FSA* shall not be considered a group health plan for coordination of *benefits* purposes, and *health FSA benefits* shall not be taken into account when determining benefits payable under any other plan.
3. **Records.** Certain facts are needed for *Flex Plan* administration and *claim* processing. By enrolling for coverage under the *Flex Plan*, you authorize the *TPA* to get the facts it needs from or give them to third parties where such release is reasonably necessary. The confidentiality of such information will be maintained by the *TPA* in accordance with existing law. This authorization applies to you

and each covered *dependent*, regardless of whether each covered *dependent* signs the application for enrollment.

Article V. Dependent Care FSA Benefit

A. *Benefits*

An eligible employee can participate in the *dependent care FSA benefit* by enrolling and electing to receive *benefits* in the form of reimbursements for *dependent care expenses* (*dependent care FSA benefits*). *Benefits* elected will be paid by *employee contributions*. Unless an exception applies (as described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", such election is irrevocable for the duration of the *period of coverage* to which it relates.

B. *Dependent Care FSA Benefit Contributions for Cost of Coverage*

The annual contribution for a *covered employee's dependent care FSA benefits* is equal to the annual *benefit* amount elected by the *covered employee* (for example, if the maximum \$5,000 annual *benefit* amount for married persons filing jointly is elected, the annual contribution amount is also \$5,000).

C. *Eligible Dependent Care Expenses (a.k.a. Covered Expenses)*

Under the *dependent care FSA benefit*, a *covered employee* may receive reimbursement only for *dependent care expenses incurred* during the *period of coverage* for which an election is in force.

1. ***Incurred.*** A *dependent care expense* is incurred at the time the *qualifying dependent care services* giving rise to the expense is furnished, and not when the *covered employee* is formally billed, charged, or pays for such services (e.g., services rendered for the month of June are not fully *incurred* until June 30 and cannot be reimbursed in full until then).
2. ***Dependent Care Expenses.*** "*Dependent care expenses*" means expenses that are considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for the care of a *qualifying individual* and enable the *covered employee* and spouse to actively seek employment, or if your non-working spouse is a full-time student or incapable of self care), and expenses for incidental household services, if paid for by the *covered employee* to obtain *qualifying dependent care services*, but only to the extent that the *covered employee* or *spouse* is not reimbursed for the expense (nor is the expense reimbursable) through insurance or any other plan. If only a portion of a *dependent care expense* is reimbursed elsewhere (e.g. because the *spouse's* employer's dependent care FSA benefit imposes maximum benefit limitations), the *dependent care FSA benefit* can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article entitled, "*Dependent Care FSA Benefit*".
3. ***Qualifying Individual.*** "*Qualifying individual*" means:
 - a. a *covered employee's* tax dependent child or qualifying relative (as described in Code Section 152 (a) (1)) who is a qualified child under the age of thirteen (13);
 - b. a *covered employee's* dependent (as described in Code Section 21 (b) (1) (B)) or *spouse* who is mentally or physically incapable of self-care, and has same principal place of residence as the *covered employee* for more than half of the taxable year and whose gross income does not exceed a federal exemption amount during that calendar year; or

- c. a *covered employee's* child that is deemed to be a *qualifying individual* described in paragraph 3. a. or b. above, whichever is appropriate, pursuant to *Code* Section 21 (e) (5).
4. **Qualifying Dependent Care Services.** “*Qualifying dependent care services*” means the following services that both:
- a. relate to the care of a *qualifying individual* and enables the *covered employee* and his or her *spouse* to remain gainfully employed after the date of participation in the *dependent care FSA benefit* and during the *period of coverage*; and
 - b. are performed:
 - (1) in the *covered employee's* home; or
 - (2) outside the *covered employee's* home for:
 - a. the care of a *covered employee's* dependent (as described in *Code* Section 152 (a) (1)) who is under age 13; or
 - b. the care of any other *qualifying individual* who regularly spends at least eight hours per day in the *covered employee's* household.

If the expenses are *incurred* for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.

5. **Exclusion.** *Dependent care expenses* do not include amounts paid to:
- a. an individual with respect to whom a personal exemption is allowable under *Code* Section 151(c) to a *covered employee* or his or her *spouse*;
 - b. a *covered employee's* spouse; or
 - c. a *covered employee's* child (as described in *Code* Section 152 (f) (1)), who is under 19 years of age at the end of the calendar year in which the expenses were *incurred*.

D. Maximum Benefits

1. **Maximum Reimbursement Benefits Available; Code Limitations.** The maximum dollar amount elected by the *covered employee* for reimbursement of *dependent care expenses incurred* during a *period of coverage* (reduced by prior reimbursements during the same *period of coverage*) shall only be available during the *period of coverage* to the extent of the actual amounts credited to the *covered employee's dependent care FSA benefit account* pursuant to the “Establishment of Account” section. No reimbursement will be made to the extent that such reimbursement would exceed the balance in the *covered employee's account* (that is, the year-to-date amount that has been withheld from the *covered employee's compensation* for reimbursement for *dependent care expenses* for the *period of coverage*, less any prior reimbursements). Reimbursement and payment shall be made to the *covered employee* in the form of a check drawn on a bank account or, if elected by the *covered employee*, by direct deposit to the *covered employee's* designated financial/bank account, as reimbursement for *dependent care expenses incurred* during the *period of coverage* for which the *covered employee's* election is effective, provided that the other requirements of this entitled, “*Dependent Care FSA Benefit*” are met. Notwithstanding the foregoing, no reimbursement otherwise due to a *covered employee* shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the *plan year*, would exceed the

applicable statutory limit. The applicable statutory limit for a *covered employee* is the smallest of the following amounts:

- a. the *covered employee's earned income* for the calendar year;
- b. the *earned income* of the *covered employee's spouse* for the calendar year (a *spouse* who is not employed during a month in which the *covered employee incurs a dependent care expense*, and is either physically or mentally incapable of self-care or a student (as defined by *Code* Section 21 (e) (7)) shall be deemed to have *earned income* of \$250 per month per *qualifying individual* for whom the *covered employee incurs dependent care expenses*, up to a maximum amount of \$500 per month); or
- c. Either \$5,000 or \$2,500 for the calendar year, as applicable:
 - (1) \$5,000 for the calendar year if one of the following applies:
 - a. the *covered employee* is married and files a joint return;
 - b. the *covered employee* is married, but
 - i. furnishes more than one-half the cost of maintaining the *qualifying individual* and maintains a household that has the same principal place of abode as the *qualifying individual* for whom the *covered employee* is eligible to receive reimbursements under the *dependent care FSA benefit*;
 - ii. the *covered employee's spouse* maintains a separate residence for the last six months of the calendar year; and
 - iii. the *covered employee* files a separate tax return; or
 - c. the *covered employee* is single or the head of the household for tax purposes; or
 - (2) \$2,500 for the calendar year if the *covered employee* is married and resides with the *spouse*, but files a separate federal income tax return.

For purposes of this section *earned income* means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation benefits), but only if such amounts are included in gross income for the taxable year. *Earned income* does not include (a) any amounts received pursuant to any *dependent care FSA benefit* established under *Code* Section 129; or (b) any other amounts excluded from *earned income* under *Code* Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

2. **Maximum Dollar Limits.** The maximum annual *benefit* amount that a *covered employee* may elect to receive under this *Flex Plan* in the form of reimbursements for *dependent care expenses incurred* in any *period of coverage* shall be \$5,000 (subject to the other limitations described above, and subject to 3. below).
3. **Changes; No Proration.** For *plan years* that begin after the effective date, the maximum dollar limit may be changed by the *Flex Plan Administrator* and shall be communicated to eligible employees through the *election form/salary reduction agreement* or another document. If a *covered employee* enrolls for *dependent care FSA benefits* mid-year, or increases his or her election mid-year as permitted under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", there will be no proration of the dollar limit (i.e., the *covered employee* may elect

coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable).

4. **Effect on Maximum Reimbursement Benefits if Election is Changed.** Any change in an election under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", affecting annual contributions to the *dependent care FSA benefit* also will change the maximum reimbursement *benefits* for the remainder of the *period of coverage* commencing with the election change, as further limited by the Article entitled, "*Dependent Care FSA Benefit*", D.1. Such maximum reimbursement *benefits* for the remainder of the *period of coverage* shall be calculated by adding: (1) the aggregate contribution to the *dependent care FSA* for the period prior to such election change to, (2) the total contribution for the remainder of such *period of coverage*, reduced by (3) all prior reimbursements made during the entire *period of coverage*.

E. Establishment of Account

The *Flex Plan Administrator* will establish a *dependent care FSA benefit account* with respect to each *covered employee* who participates in the *dependent care FSA benefit*, but will not create a separate fund or otherwise segregate assets for this purpose. The *account* so established will merely be a recordkeeping *account* for purposes of tracking contributions and determining forfeitures.

1. **Crediting of Accounts.** A *covered employee's dependent care FSA benefit account* will be credited periodically during each *period of coverage* in an amount equal to the *covered employee's salary reductions* allocable to such *account*.
2. **Debiting of Accounts.** A *covered employee's dependent care FSA benefit account* will be debited during each *period of coverage* for any reimbursement of *dependent care expenses incurred* during the *period of coverage*. The amount available for reimbursement *benefits* is described in the Article entitled, "*Dependent Care FSA Benefit*", D. above. A *covered employee's dependent care FSA benefit account* may not have a negative balance during a *period of coverage*.

F. Forfeiture of Accounts; Use-It-Or-Lose-It Rule

If any balance remains in the *covered employee's dependent care FSA benefit account* for a *period of coverage* after all reimbursement *benefits* have been made for such period, the balance shall not be carried over to reimburse the *covered employee* for *dependent care expenses incurred* during a subsequent *plan year*. As required by the *Code*, the *covered employee* shall forfeit all rights with respect to such balance. All forfeitures under this *Flex Plan* shall be used as follows: first, to reduce the cost of administering this *Flex Plan* during the *plan year* or subsequent *plan years*, and second, to provide increased *benefits* or compensation to *covered employees* in subsequent years as the *Flex Plan Administrator* deems appropriate, consistent with applicable laws and regulations. In addition, any *dependent care FSA benefit* payments that are unclaimed (e.g., uncashed benefit checks) by the end of the *plan year* after the *period of coverage* in which the *dependent care expense* was *incurred*, shall be forfeited and applied as described above.

G. Reimbursements and Initial Benefit Determinations of Post-Service Claims

1. **Post-Service Claims.** Post-service *claims* are *claims* that are filed for payment and reimbursement of *benefits* under the *Flex Plan* after *medical care expenses* or *dependent care expenses* (as applicable) have been *incurred* and submitted in accordance with the post-service *claim* substantiation and filing procedures for the *Flex Plan*.

2. **Substantiation and Filing Procedures for Post-Service Claims.** A *covered employee* who has elected to receive *dependent care FSA benefits* may apply for reimbursement by submitting a complete written *claim* request for reimbursement to the *TPA* at the address noted inside the cover page of this *SPD*, by no later than the last day of the fourth calendar month following the close of the *plan year* in which the *dependent care expense* was *incurred*, and setting forth the following essential data elements:
- the person or persons on whose behalf *dependent care expenses* have been *incurred*;
 - the nature and date of the expenses so *incurred*;
 - the amount of the requested reimbursement;
 - the name of the person, organization or entity to whom the expense was or is to be paid; and
 - a statement that such expenses have not otherwise been paid and are not expected to be paid through any other source.

The reimbursement claim must be accompanied by bills, invoices, or other written statements from an independent third party showing that the *dependent care expenses* have been *incurred* and the amounts of such expenses, together with any additional documentation that the *TPA* may request or the *Flex Plan Administrator* may require. Except for the final reimbursement *claim* for a *period of coverage*, no *claim* for reimbursement may be made unless and until the aggregate *claims* for reimbursement is at least \$25. If *you* have not submitted the post-service *claim* in accordance with these filing procedures, including a failure to submit all essential data elements, *your* post-service *claim* will be treated as incorrectly filed. Please note that the time periods (below) for making an initial benefit determination begin when the *TPA* receives a written post-service *claim* submitted in accordance with the *Flex Plan's* filing procedures.

Please note that federal tax laws require *you* to report the taxpayer identification number (Social Security number, if an individual) of the person, organization or entity to whom the expense is paid on *your* annual income tax return.

3. **Timing of Initial Benefit Determinations.** Within 30 calendar days after receipt of a properly filed reimbursement *claim* from a *covered employee*, the *Flex Plan* will reimburse the *covered employee* for the *covered employee's dependent care expenses*, or the *covered employee* will be notified that his or her *claim* has been denied. If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Flex Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial benefit determination, it may extend the time period for the initial benefit determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 30-calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial benefit determination within 15 calendar days after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied.

The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA's* control.

If *your* post-service *claim* is denied, written notification will be provided to *you*. This notice will explain:

- the reason for the denial;
- the part of the *Flex Plan* on which it is based;

- c. any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
 - d. the procedure for requesting an appeal.
4. **Claims Denied.** To appeal a denied *claim* for *dependent care FSA benefits* reimbursement, refer to the appeals procedure in the Article entitled, "Appeals Procedure".
 5. **Reimbursements After Termination.** When a *covered employee* ceases to be a *covered employee* and participation terminates under this *Flex Plan*, the *covered employee's salary reductions* and election to receive reimbursements will automatically terminate, subject to the following: such *covered employee* (or the *covered employee's estate*) may *claim* reimbursement for *dependent care expenses incurred* during the *period of coverage* prior to termination of participation, including expenses *incurred* in the calendar month that includes the termination date if such month is in the current *plan year*, provided that the *covered employee* (or the *covered employee's estate*) files a *claim* by the last day of the fourth calendar month following the close of the *plan year* in which the *dependent care expense* was *incurred*.

H. Report To Covered Employees

On or before January 31 of each year, the *Flex Plan Administrator* shall furnish to each *covered employee* who has received reimbursement for *dependent care expenses* during the prior calendar year a written statement showing the *dependent care expenses* paid during such year with respect to the *covered employee*, or showing the *salary reductions* for the year for *dependent care FSA benefits*, as the *Flex Plan Administrator* deems appropriate.

Article VI. Premium Payment Benefits

A. Premium Payment Benefits

The *benefit* that can be elected as *premium payment benefits* is pre-tax payment of medical *group benefit program premiums* (includes PPO, HMO high deductible options but excluding contributions/premiums toward any HRA component).

The *covered employee* is required to elect core *benefits* consisting of *medical group benefit program* unless he/she timely provides satisfactory proof of other coverage to the *employer*. *Premium payment benefits* will be funded by *employer* and *covered employee contributions* as provided in the Article entitled, "*Benefits Offered, Contributions and Flex Plan Payments*". Only *qualified benefits* may be elected under this *Flex Plan*.

Unless an exception applies (as described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", such election is irrevocable for the duration of the *period of coverage* to which it relates.

B. Premium Payment Benefits Contributions for Cost of Coverage

The annual *premium* for a *covered employee's premium payment benefits* is equal to the amount as set by the *employer*, which may or may not be the same amount charged by the payor or carrier, if any, for the applicable *group benefit program*.

C. **Benefit Provided Under the Applicable Group Benefit Program**

All benefits and coverages under the *group benefit programs* will be provided by separate medical *group benefit programs*, as applicable, not this *Flex Plan*. The types and amounts of such benefits, the requirements for participating in the applicable programs, and the other terms and conditions of coverage and benefits of the programs are set forth in the applicable certificates of coverage, insurance policy and summary plan description documents for each program. All claims to receive benefits and appeals of denied claims under these programs shall be subject to and governed by the terms and conditions of the applicable *group benefit programs* and the rules, regulations, policies and procedures from time to time adopted in accordance therewith, as may be amended from time to time.

D. **Health Benefits; COBRA**

Notwithstanding any provision to the contrary in this *Flex Plan*, to the extent required by *COBRA*, a *covered employee* and his or her *spouse* and *dependents*, whose coverage terminates under the medical *group benefit programs* because of a *COBRA* qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the *premium payment benefits* the day before the qualifying event for the periods prescribed by *COBRA* (subject to all conditions and limitations under *COBRA*), with *premiums* for such coverage to be paid on an after-tax basis unless determined otherwise by the *Flex Plan Administrator* on a uniform and consistent basis (but not beyond the current *plan year*).

Article VIII. Election Change Events (Exceptions to Irrevocable Elections)

A. **Procedure for Making New Election (i.e., Change an Election)**

1. **Timing for When New Election Must Be Made.** A *covered employee* (or an eligible employee who, when first eligible or during the *annual enrollment period*, declined to be a *covered employee*) may make a new election within 30 calendar days of the occurrence of an event described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", but only if the election under the new *election form* is made on account of and is consistent with the event, and the election is made within any specified time period (e.g., for the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", within 30 calendar days of the events described therein).

Notwithstanding the foregoing, a *change in status*, such as a divorce or a *dependent's* ineligibility due to marriage age or loss of student status, that results in a *spouse* or *dependents* becoming ineligible shall automatically result in a change in elections, even if not requested by the *covered employee*.

2. **Effective Date of New Election.** Elections made pursuant to this section shall be effective for the remainder of the *period of coverage* following the change of election unless a subsequent event allows for a further election change. *Medical Premium Payment Benefits* only: Except as provided in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", for *HIPAA* special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the pay period following the date that the election change was filed or in the case of *premium payment benefits*, a later effective date as provided by the applicable *group benefit program*).

3. **Effect of New Election upon Amount of FSA Benefits.** For the effect of a changed election upon the maximum *benefits* under *health FSA benefits* and *dependent care FSA benefits*, see the Article entitled, "*Health FSA Benefits*", and the Article entitled, "*Dependent Care FSA Benefit*", respectively.

B. *Change in Status Defined*

A *covered employee* may make a new election (i.e., change an election) upon the occurrence of certain events as described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", C., including upon a *change in status*, for the applicable *Flex Plan benefits*. "*Change in Status*" means any of the events described below, and any other events permitted under subsequent changes to Code Section 125 or regulations issued thereunder, which the *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this *Flex Plan*:

1. **Legal Marital Status.** A change in a *covered employee's* legal marital status, including marriage, death of a *spouse*, divorce, legal separation, or annulment;
2. **Number of Dependents.** Events that change a *covered employee's* number of *dependent child(ren)*, including birth, death, adoption, and placement for adoption of a child;
3. **Dependent Eligibility Status.** An event that causes a *dependent child* to satisfy the dependent eligibility requirements for a particular *benefit*, such as gaining student status, changing from married to unmarried status, handicapped status, or any similar circumstance;
4. **Dependent Ineligibility Status.** An event that causes a *dependent child* to cease to satisfy *dependent* eligibility requirements for a particular *benefit*, such as attaining a specified age, loss of student status, becoming married or loss of handicapped status; and
5. **Employment Status.** Any of the following events that change the employment status of the *covered employee*, his/her *spouse*, or *dependent*:
 - a. a termination or commencement of employment, strike or lockout;
 - b. a commencement of or return from an unpaid leave of absence or a change in worksite by the *covered employee*, his/her *spouse*, or *dependent*; and
 - c. if the eligibility conditions of this *Flex Plan* or another employee benefit plan of the employer of the *covered employee*, his or her *spouse*, or *dependent* depend on the employment status of the *covered employee*, his/her *spouse*, or *dependent* and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this *Flex Plan* or another employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the plan, then that change qualifies as a change in employment status.

C. Permitted Events and Election Changes

A *covered person* entitled to change an election as described in this Article must do so in accordance with the procedures described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)".

A *covered employee* may change an election (including make a new election) as described below upon the occurrence of the listed events for the applicable *premium payment benefits, health FSA benefits and/or dependent care FSA benefits* of this *Flex Plan*:

1. **Annual Enrollment Period (Applies to Premium Payment Benefits; Health FSA Benefits, and Dependent Care FSA Benefits).** A *covered employee* may change an election during the *annual enrollment period* in accordance with the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves".
2. **Termination of Employee's Employment or Loss of Eligibility (Applies to Premium Payment Benefits; Health FSA Benefits, and Dependent Care FSA Benefits).** A *covered employee's* election will automatically terminate under the *Flex Plan* upon termination of employment or the employee ceasing to be eligible for the applicable *group benefit program* in accordance with the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves", as applicable.
3. **Leaves of Absence (Applies to Premium Payment Benefits; Health FSA Benefits and Dependent Care FSA Benefits).** A *covered employee* may change an election under the *Flex Plan* upon *FMLA* leave and upon non-*FMLA* leave in accordance with the Article entitled, "Eligibility, Enrollment and Participation, and Termination and Leaves"
4. **Change in Status (Applies to Premium Payment Benefits; Health FSA Benefits; and Dependent Care FSA Benefits as Limited Below).** A *covered employee* may change his or her election under the *Flex Plan* upon the occurrence of a *change in status* as defined above, but only if such election change is made on account of and consistent with a *change in status* that affects eligibility for coverage under a plan of the *employer* or of the *spouse's* or *dependent's* employer (referred to as the general consistency requirement). A *change in status* that affects eligibility for coverage under a plan of the *employer* or of the *spouse's* or *dependent's* employer includes a *change in status* that results in an increase or decrease in the number of a *covered employee's* family members (i.e., a *spouse* and/or *dependents*) who may benefit from the coverage.

Election changes may not be made to reduce *health FSA* coverage or *salary reduction* contribution amounts to a *health FSA* during a *period of coverage*; however, election changes may be made to cancel *health FSA* coverage and *salary reduction* contributions completely due to the occurrence of any of the following events: death of a *spouse*, divorce, legal separation, annulment, or death of a *dependent*, or change in employment status that causes the *covered employee* to become ineligible for *health FSA benefits* or a *dependent's* ceasing to satisfy eligibility requirements for *health FSA benefits* on account of attaining a certain age, etc. However, such cancellation will not become effective to the extent it would reduce future contributions to the *health FSA* to a point where total *plan year* contributions are less than amounts previously reimbursed for such *plan year*. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, shall determine, whether a requested change is on account of and consistent with a *change in status*. If the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements (below) in order for a *covered employee* to be able to change his or her election based on the *change in status*:

- a. **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** For a *change in status* involving a *covered employee's* divorce, legal separation, or annulment, from a *spouse*, the death of a *spouse* or a *dependent*, or a *dependent's* ceasing to satisfy the eligibility requirements for coverage, a *covered employee* may only elect to cancel *group benefit program* coverage for:
 1. the *spouse* involved in the divorce, legal separation, or annulment;

2. the deceased *spouse* or *dependent*; or
3. the *dependent* that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that *change in status*. Notwithstanding the foregoing, if the *covered employee* or his or her *spouse* or *dependent* becomes eligible for *COBRA* (or similar health plan continuation coverage under state law) under the *employer's* plan (and the *covered employee* remains a *covered employee* under this *Flex Plan*), the *covered employee* may increase his or her election to pay for such coverage (however, this rule does not apply to a *covered employee's spouse* who becomes eligible for *COBRA* or similar coverage as a result of divorce, legal separation, or annulment).

If a *dependent* child ceased to satisfy eligibility requirements because of attainment of specified age for a particular *benefit*, or *group benefit program*, a *covered employee's* election including *premium payment benefits* election with respect to such *dependent* will automatically terminate under the *Flex Plan* upon cessation of coverage under the applicable *benefit*, or program.

- b. **Gain of Coverage Eligibility Under Another Employer's Plan.** For a *change in status* in which a *covered employee* or his or her *spouse* or *dependent* gains eligibility for coverage under a cafeteria plan or *qualified benefit plan* of the employer of the *covered employee's spouse* or *dependent* as a result of a change in marital status or a change in employment status, a *covered employee* may elect to cease or decrease *premium payment benefits* and *health FSA* coverage for that individual only if coverage for that individual becomes effective or is increased under the *spouse's* or *dependent's* employer's plan. The *Flex Plan Administrator* may rely on a *covered employee's* certification that the *covered employee* has obtained or will obtain coverage under the *spouse's* or *dependent's* employer's plan.
 - c. **Special Consistency Rule for *Dependent Care FSA Benefits*.** A *covered employee* may change or terminate his or her *dependent care FSA benefits* election and associated *salary reduction* upon a *change in status* if:
 1. such change or termination is made on account of and consistent with a *change in status* that affects eligibility for coverage under the *Flex Plan* for *dependent care FSA benefits*; or
 2. the election change is on account of and consistent with a *change in status* that affects eligibility of *dependent care expenses* for the tax exclusion under *Code* Section 129.
5. **Judgments, Decrees and Orders (Applies to *Premium Payment Benefits* that Provide Medical or Dental Coverage, to *Health FSA Benefits*, but not to *Dependent Care FSA Benefits*).** If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires medical or dental coverage or an election for *health FSA benefits* for a *covered employee's dependent* child (including a foster child who is a *dependent* of the *covered employee*), a *covered employee* may:
- a. change his or her election and *salary reduction agreement* to provide coverage for the *dependent* child (provided that the order requires the *covered employee* to provide such coverage); or
 - b. change his or her prior election and now revoke coverage for the *dependent* child if the Order requires that another individual (including the *covered employee's spouse* or former

spouse) provide coverage under that individual's plan and such coverage is actually provided.

7. Medicare and Medicaid (Applies to *Premium Payment Benefits* that are Group Medical Programs, to *Health FSA Benefits* as Limited Below, but Not to *Dependent Care FSA Benefits*).

If a *covered employee* or his or her *spouse* or *dependent* who is enrolled in a group health program under this *Flex Plan* becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefit under Section 1928 of the Social Security Act providing for pediatric vaccines), the *covered employee* may prospectively cancel or reduce the group medical program coverage of the individual so entitled, and may cancel (but not reduce) *health FSA benefits*. Further, if a *covered employee* or his or her *spouse* or *dependent* who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the *covered employee* may prospectively elect to commence or increase medical program coverage.

8. Change in Cost (Applies to *Premium Payment Benefits*, to *Dependent Care FSA Benefits* as Limited Below, but Not to *Health FSA Benefits*). For purposes of this Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", "similar coverage" means coverage for the same category of benefit for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition:

- a. a *health FSA* is not similar coverage with respect to an accident or medical plan that is not a *health FSA*,
- b. HMO, PPO, and high deductible options are considered to be similar coverage, and
- c. coverage by another employer, such as a *spouse's* or *dependent's* employer, is treated as similar coverage.

(1) **Increase or Decrease for Insignificant Cost Changes.** A *covered employee's* elective contributions (*salary reductions*) will be automatically increased to reflect insignificant increases in the required contribution for the *benefit package option(s)*, and the elective contributions (*salary reductions*) will be automatically decreased to reflect insignificant decreases in the required contribution. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant.

(2) **Significant Cost Increases.** If the *Flex Plan Administrator* determines that the cost charged to a *covered employee* for a *benefit package option(s)* (such as the HMO) significantly increases during a *period of coverage*, the *covered employee* may:

- a. make a corresponding prospective increase in his or her elective contributions (by increasing *salary reductions*);
- b. revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another *benefit package option* offered by the *employer* that provides similar coverage (such as the PPO, but not the *health FSA*); or
- c. cancel coverage prospectively if there is no other *benefit package option* available that provides similar coverage. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

(3) **Significant Cost Decreases.** If the *Flex Plan Administrator* determines that the cost of any *benefit package option* (such as the PPO) significantly decreases during a *period of coverage*, the *Flex Plan Administrator* may permit the following election changes: (a) *covered employees* who are enrolled in that *benefit package option* may make a corresponding prospective decrease

in his or her elective contributions (by decreasing *salary reductions*); (b) *covered employees* who are enrolled in a *benefit package option* (such as the HMO, but not the *health FSA*) other than the *benefit package option* that has decreased in cost may change their election on a prospective basis to elect the *benefit package option* that has decreased in cost (such as the PPO); or (c) eligible employees who are otherwise eligible under the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves." A. may elect the *benefit package option* that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the *benefit package option*. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.

- (4.) **Significant Cost Increases for Dependent Care FSA Benefits.** If the *Flex Plan Administrator* determines that the cost charged to a *covered employee* for *dependent care FSA benefits* significantly increases during a *period of coverage* due to increased costs imposed by an independent care provider who is not a relative of the *covered employee*, the *covered employee* may:
- a. make a corresponding prospective increase in his or her elective contributions (by increasing *salary reductions* for *dependent care FSA benefits*); or
 - b. cancel *dependent care FSA benefits* prospectively if there is no other *benefit package option* available that provides similar coverage. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

- (5.) **Significant Cost Decreases for Dependent Care FSA Benefits.** If the *Flex Plan Administrator* determines that the cost charged for *dependent care FSA benefits* significantly decreases during a period of coverage due to decreased costs imposed by an independent care provider who is not a relative of the *covered employee*, the *Flex Plan Administrator* may permit the following election change:
- a. eligible employees who are otherwise eligible under this *Flex Plan* may elect the *dependent care FSA benefit* on a prospective basis. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.

9. **Change in Coverage (Applies to Premium Payment Benefits, to Dependent Care FSA Benefits, but Not to Health FSA Benefits).** The definition of "similar coverage" under the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", applies also to this Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)",

- a. **Significant Curtailment.** If coverage is "significantly curtailed" (as defined in subsection (1) below), *covered employees* may elect coverage under another *benefit package option* that provides similar coverage. In addition, as set forth in subsection (2) below, if the coverage curtailment results in a "loss of coverage" (as defined in subsection (3) below), *covered employees* may drop coverage if no similar coverage is offered by the *employer*. The *Flex Plan Administrator* in its sole discretion, on a uniform and consistent basis, will decide, whether a curtailment is "significant," and whether a *loss of coverage* has occurred.

- (1) **Significant Curtailment Without Loss of Coverage.** If the *Flex Plan Administrator* determines that a *covered employee's* coverage under a *benefit package option* under this *Flex Plan* (or the *covered employee's spouse's* or *dependent's* coverage under his or her *employer's* plan) is significantly curtailed without a *loss of coverage* (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing

limit under an accident or health plan, such as the PPO) during a *period of coverage*, the *covered employee* may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another *benefit package option* that provides similar coverage (such as the HMO, but not the *health FSA*). Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

- (2) **Significant Curtailment With a Loss of Coverage.** If the *Flex Plan Administrator* determines that a *covered employee’s benefit package option* (such as the PPO) coverage under this *Flex Plan* (or the *covered employee’s spouse’s or dependent’s* coverage under his or her *employer’s* plan) is significantly curtailed, and such curtailment results in a *loss of coverage* during a *period of coverage*, the *covered employee* may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another *benefit package option* that provides similar coverage (such as the HMO, but not the *health FSA*), or drop coverage if no other *benefit package option* providing similar coverage is offered by the *employer*.
- (3) **Definition of Loss of Coverage.** For purposes of the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", a “*loss of coverage*” means a complete *loss of coverage* (including the elimination of a *benefit package option*, the HMO ceasing to be available where the *covered employee* or his or her *spouse or dependent* resides, or a *covered employee* or his or her *spouse or dependent* losing all coverage under the *benefit package option* by reason of an overall lifetime or annual limitation). In addition, the *Flex Plan Administrator* in its sole discretion, on a uniform and consistent basis, may treat the following as a *loss of coverage*:
 - a. a substantial decrease in the medical care providers available under the *benefit package option* (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO or the HMO);
 - b. a reduction in *benefits* for a specific type of medical condition or treatment with respect to which the *covered employee* or his or her *spouse or dependent* is currently in a course of treatment; or
 - c. any other similar fundamental *loss of coverage*.
- b. **Addition or Significant Improvement of a Benefit Package Option.** If during a *period of coverage*, the *Flex Plan* adds a new *benefit package option* or significantly improves an existing *benefit package option*, the *Flex Plan Administrator* may permit the following election changes:
 - (1) *covered employees* who are enrolled in a *benefit package option* other than the newly-added or significantly improved *benefit package option* may change their election on a prospective basis to elect the newly-added or significantly improved *benefit package option*; and
 - (2) *covered employees* who are otherwise eligible may elect the newly added or significantly improved *benefit package option* on a prospective basis, subject to the terms and limitations of the *benefit package option*. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a *benefit package option*.

- c. **Loss of Coverage Under Other Government or Educational Institutional Group Health Coverage.** A *covered employee* may prospectively change his or her election to add group health coverage for the *covered employee* or his or her *spouse* or *dependent*, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in *Code* Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefit risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable *benefit package option(s)*.

- d. **Change in Coverage Under Another Employer Plan.** A *covered employee* may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the *employer* or a plan of the *spouse's* or dependent's employer), so long as (a) the other cafeteria plan or *qualified benefits* plan permits its *covered employees* to make an election change that would be permitted under applicable IRS regulations; or (b) this *Flex Plan* permits *covered employees* to make an election for a *period of coverage* that is different from the plan year under the other employer's cafeteria plan or *qualified benefits* plan. For example, if an election is made by the *covered employee's spouse* during his or her employer's open enrollment to drop coverage, the *covered employee* may add coverage to replace the dropped coverage. The *Flex Plan Administrator*, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan.

- e. **Dependent Care FSA Benefits Coverage Changes.** A *covered employee* may make a prospective election change that is on account of and consistent with a change by the *covered employee* in the dependent care service provider. For example:
 - (1) if the *covered employee* terminates one dependent care service provider and retains a new dependent care service provider, the *covered employee* may change coverage to reflect the cost of the new service provider; and
 - (2) if the *covered employee* terminates a dependent care service provider (for example: because a relative becomes available to take care of the child at no charge), the *covered employee* may cancel coverage.

A *covered employee* entitled to change an election as described in this Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", must do so in accordance with the procedures described in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)".

D. Automatic Election Modifications Required Under *Flex Plan* or By *Flex Plan Administrator*

Benefit elections and *salary reductions* will automatically terminate as provided in the Article entitled, "Election Change Events (Exceptions to Irrevocable Elections)", due to cessation of eligibility.

The *Flex Plan Administrator* also may, at any time, automatically modify or cancel the *salary reduction* and *benefits* election of a *covered employee* or class of *covered employees* for a *period of coverage* if the *Flex Plan Administrator* determines that such action is necessary or advisable to:

1. satisfy any of the *Code's* nondiscrimination requirements applicable to this *Flex Plan*, the *benefits* or other cafeteria plan;
2. prevent any *covered employee* or class of *covered employees* from having to recognize more income for federal income tax purposes from the receipt of benefit hereunder than would otherwise be recognized;
3. maintain the qualified status of *benefits* received under this *Flex Plan*; or
4. satisfy *Code* nondiscrimination requirements or other limitations applicable to the *employer's* qualified plans.

Article IX. Appeals Procedure

The following procedures apply to *benefits* and *claims* denied under the *Flex Plan*. Any claim for *benefits* or coverages under the *other group benefit programs*, including group medical and dental will be administered in accordance with the claim and appeal procedures applicable to each such program as set forth in the group insurance policies, certificates of coverage, and summary plan descriptions for the applicable programs.

A. Post-Service Claims

If *your* post-service *claim* for *benefits* under the *Flex Plan* is wholly or partially denied, *you* or *your* authorized representative may submit an appeal in accordance with this subsection.

1. *You* or *your* authorized representative may do the following:
 - a. within 180 calendar days after receiving notice that *your* post-service *claim* was denied for *FSA benefits*, submit a written first appeal to the TPA Customer Service Department address as shown on the inside cover of this *SPD* and for *premium payment benefits*, submit a written first appeal to the *Flex Plan Administrator*, at the address noted on the last page of this *SPD*, and
 - b. submit issues, comments and additional information as appropriate.
2. Within 30 calendar days after *your* written first appeal is received, a decision on *your* appeal will be made and communicated by the *TPA* in the case of *FSA benefits* appeals, and by the *Flex Plan Administrator* in the case of *premium payment benefits* appeals. *You* will receive a copy of the decision, including the specific reasons for it and references to the part of the *Flex Plan* on which it is based, and the procedure for requesting a second appeal from the *Flex Plan Administrator*. This time period may be extended if *you* agree.
3. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may do the following:
 - a. submit a written second appeal request for *FSA benefits* to the *TPA* Customer Service Department address as shown on the inside cover of this *SPD*, which will forward *your* appeal to the *Flex Plan Administrator* for its decision and for *premium payment benefits*, submit a written appeal request to the *Flex Plan Administrator*, at the address noted on the last page of this *SPD*; and
 - b. submit issues, comments and additional information as is appropriate.

4. Within 30 calendar days after *your* written second appeal is received, a decision on *your* appeal will be made and communicated by the *Flex Plan Administrator*. *You* will receive a copy of the *Flex Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Flex Plan* on which it is based. This time period may be extended if *you* agree.

B. Access To Relevant Documents For *Health FSA Benefits*

Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your claim* for *health FSA benefits* under the *Flex Plan*.

Article X. General Provisions

A. No Guarantee of Employment or Overall *Benefits*

The adoption and maintenance of this *Flex Plan* does not guarantee or represent that the *Flex Plan* will continue indefinitely with respect to any class of employees and shall not be deemed to be a contract of employment between the *employer* and any *covered employee*. Nothing contained herein shall give any *covered employee* the right to be retained in the employ of the *employer* or to interfere with the right of the *employer* to discharge any *covered employee*, at any time, nor shall it give the *employer* the right to require any *covered employee* to remain in its employ or to interfere with the *covered employee's* right to terminate his or her employment at any time not inconsistent with any applicable employment contract. Nothing in this *Flex Plan* shall be construed to extend *benefits* for the lifetime of any *covered person* or to extend *benefits* beyond the date upon which they would otherwise end in accordance with the provisions of the *Flex Plan* or any benefit description.

B. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of *Benefits*. *Covered employees* who are absent due to service in the uniformed services and/or their covered *dependents* may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

Eligibility. A *covered employee* is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered dependents who have coverage under the *Plan* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following his or her leave under USERRA, no *waiting periods* or pre-existing condition limitations, if applicable, will apply.

Premium Payment. If continuation of *Plan* coverage is elected under USERRA, the *covered employee* or covered *dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the Employer.

Duration of Coverage. Elected continuation coverage under USERRA will continue until the earlier of:

1. 24 months, beginning the first day of absence from employment due to service in the uniformed services;
2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;
3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or
4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under “COBRA Continuation Coverage.” *Covered employees* should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period.
2. 31 to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.
3. 181 days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.
4. Service-connected *injury* or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

C. **COBRA Continuation Coverage (Applies to Health FSA Benefits Only)**

The *covered employee*, his or her covered *spouse* and covered *dependent* children under the *health FSA* portion of the *Flex Plan* may continue coverage under such portion when a qualifying event occurs. *You* may elect *COBRA* for yourself regardless of whether the *covered employee* or other eligible dependents in *your* family elect *COBRA*. A *covered employee* and a covered *spouse* may elect *COBRA* on behalf of each other and/or their covered *dependent* children. If a loss of coverage qualifying event occurs:

1. In certain cases, the *covered employee* may continue his or her coverage and may also continue coverage for his or her covered *spouse* and covered *dependent* children when coverage would normally end;
2. In certain cases, the covered *spouse* and covered *dependent* children may continue coverage when coverage would normally end;
3. Coverage will be the same as that for other similar *covered persons*; and
4. Continuation coverage for *health FSA benefits* under this *Flex Plan* ends when this *Flex Plan* terminates or upon the occurrence of other events permitted by *COBRA*.

Your *employer* has contracted with PreferredOne Administrative Services, Inc., to provide certain *COBRA* continuation services on behalf of the *Flex Plan* and *Flex Plan Administrator*. For general information about *your* rights and obligations under the *Flex Plan* and/or federal *COBRA* law, *you* should contact the Employer, *which* is the official *Flex Plan Administrator*. For *COBRA* notice requirements and submission information refer to the appropriate portions of this section.

The *Flex Plan's* designated COBRA Administrator is:

**PreferredOne Administrative Services
6105 Golden Hills Drive
Golden Valley, MN 55416
Phone: 763-847-4477 or 1-800-997-1750**

The *Flex Plan's* designated COBRA Administrator may change from time to time. When that happens, you will be notified of the new COBRA Administrator.

Qualifying Events

1. Loss of coverage under the *health FSA* portion of the *Flex Plan* by the *covered employee* due to one of these events:
 - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than “gross misconduct.”
 - b. Reduction in the hours of employment of the *covered employee*.
 - c. Layoff of the *covered employee*.
 - d. Leave of absence of the *covered employee*.
 - e. Early retirement of the *covered employee*.
2. Loss of coverage under the *health FSA* portion of the *Flex Plan* by the covered *spouse* and/or covered *dependent* children due to one of these events:
 - a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than “gross misconduct.”
 - b. Reduction in the hours of employment of the *covered employee*.
 - c. Layoff of the *covered employee*.
 - d. Leave of absence of the *covered employee*.
 - e. Early retirement of the *covered employee*.
 - f. *Covered employee* becoming entitled to Medicare within 18 months before the *covered employee's* hours were reduced or termination of employment for reasons other than gross misconduct.
 - g. Divorce or legal separation of the *covered employee*.
 - h. Death of the *covered employee*.
3. Loss of coverage under the *health FSA* portion of the *Flex Plan* by the covered *dependent* child due to his or her loss of “*dependent child*” status under this *Flex Plan*.
4. Loss of coverage under the *health FSA* portion of the *Flex Plan* due to the bankruptcy of the *employer* under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, his or her covered *spouse* and covered *dependent* children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, the *Flex Plan Administrator* will offer continuation coverage to qualified *covered persons*. You do not need to notify the *Flex Plan Administrator* of these qualifying events. However, for other qualifying events including

divorce or legal separation of the *covered employee* and loss of dependent child status, *COBRA* continuation is available only if *you* provide timely, written notice to the *Flex Plan Administrator* as required below by the *Flex Plan*. To elect *COBRA*, *you* must make a timely, written election as required below by the *Flex Plan*. If *you* are covered by the *health FSA* portion of the *Flex Plan*, *you* may elect continuation under that portion only.

What the *Flex Plan Administrator* must do:

1. Provide initial general *COBRA* notices as required by law;
2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;
3. Notify persons of the unavailability of *COBRA* continuation;
4. Notify the *covered person* of his or her rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered *spouse* and/or covered *dependent* children;
5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and
 6. Notify the *covered person* when he or she is no longer entitled to *COBRA* or when his or her *COBRA* continuation is ending before expiration of the required continuation period.

What *You* must do:

1. *You* must notify the *Flex Plan Administrator* in writing of a divorce or legal separation within 60 calendar days after the date of the qualifying event, or the date coverage would end due to the qualifying event, whichever is later;
2. *You* must notify the *Flex Plan Administrator* in writing of a covered *dependent* child ceasing to be eligible within 60 calendar days after the date of the qualifying event, or the date coverage would end due to the qualifying event, whichever is later;
3. *You* must submit *your* written notice of a qualifying event within the 60 day timeframe, as explained previously in Item #1 and #2, using the *Flex Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *Flex Plan Administrator*.) This notice must be submitted to the *Flex Plan Administrator* in writing and must include the following:
 - the name of the *Flex Plan*;
 - the name and address of the *covered employee* or former *covered employee*;
 - the names and addresses of all applicable *dependents*;
 - the description and date of the qualifying event;
 - documentation pertaining to the qualifying event such as: decree of divorce or legal separation, marriage certificate for child, student transcript showing last day of student enrollment for child, etc.; and
 - the name, address, and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his or her *dependent(s)*; or a representative acting on behalf of the employee or *dependent(s)*.

If *you* do not supply all notice requirements in writing as previously described, then *you* must follow the *Flex Plan Administrator's* requirements and specified time period for submitting, in writing, all required information and supporting documentation.

All written notices required for described previously in 1, 2, and 3, under “What You Must Do” must be sent to the *Flex Plan Administrator* at the address indicated in the *Flex Plan Administration Information* section of this *SPD*.

4. To elect continuation, you must notify the designated COBRA Administrator of *your* election in writing within 60 calendar days after the date the *covered person's* coverage ends, or the date the *Flex Plan Administrator* notifies the *covered person* of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Flex Plan's* approved election form. (*You* may obtain a copy of the approved form from the designated COBRA Administrator.) This election must be submitted to the designated COBRA Administrator in writing as described in this section; and
5. *You* must pay continuation premium *contributions*:
 - a. The premium *contribution* to continue coverage is the combined *employer* rate, if any, plus *covered employee* rate charged under the *health FSA* portion of the *Flex Plan*, plus the *employer* may charge an additional 2% of that rate. The continuation election form will set forth *your* continuation premium *contribution* rate(s).
 - b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
 - c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Flex Plan Administrator*.

Duration of Continuation Coverage for *Health FSA Benefits*

If *COBRA* continuation coverage is elected it will be available only for the remainder of the *plan year* in which the qualifying event occurs. *COBRA* coverage for *health FSA benefits* will cease at the end of such *plan year* and cannot be continued for the next *plan year*. *COBRA* continuation coverage may be terminated earlier upon the occurrence of certain events permitted by law, such as termination of this *Flex Plan*, failure to pay applicable *COBRA* premium contributions, coverage begins under another group health plan after *COBRA* is elected under the *health FSA benefit* portion of this *Flex Plan*, or entitlement, after *COBRA* is elected under the *health FSA* portion of this *Flex Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.

Additional Notices *You* Must Provide: Other Coverages and Medicare Entitlement

You must also provide written notice of (1) *your* other group coverage that begins after *COBRA* is elected under this *Flex Plan*; and (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after *COBRA* is elected under this *Flex Plan*.

Your written notice must be submitted using the *Flex Plan's* approved notification form within 30 calendar days of the events requiring additional notices as previously described. The notification form can be obtained from the *Flex Plan Administrator* and must be completed by *you* and timely submitted in writing to the *Flex Plan Administrator* at the address indicated in this section. In addition to providing all required information requested on the *Flex Plan's* approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after *COBRA* was elected, the name of the *covered person* who obtained other coverage, and the date that other coverage became effective.

- If providing notification of Medicare entitlement, the name and address of the *covered person* that became entitled to Medicare, and the date of the Medicare entitlement.

Special Rule for Pre-Existing Conditions

A *covered employee*, his or her *covered spouse* or *covered dependent* child who is enrolled in *COBRA* continuation under the *health FSA* portion of the *Flex Plan* and then obtains other group coverage that excludes *benefits* for pre-existing conditions applicable to such *covered person*, may choose to remain on continuation under the *health FSA* portion of the *Flex Plan* for the remainder of his or her continuation period for coverage of a pre-existing condition.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

The Federal Trade Act of 2002 gives special *COBRA* rights to *covered employees* who terminate employment or experience a reduction of hours, and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under Federal Trade Act laws. These employees may be entitled to a second opportunity to elect *COBRA* coverage for themselves and certain family members (if they did not already elect *COBRA* coverage), but only within a limited period of 60 calendar days (or less) and only during the six months immediately after their *health FSA benefits* ended.

If you qualify or may qualify for trade adjustment assistance under the Trade Act, contact the *Flex Plan Administrator* for additional information. You must contact the *Flex Plan Administrator* promptly after qualifying for trade adjustment assistance or you will lose your special *COBRA* rights.

All notices, elections, and information required to be furnished or submitted by a *covered person*, *covered spouse* or *covered dependent children* for purposes of *COBRA* continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements, and electronic e-mail do not constitute written notice and are not acceptable for *COBRA* purposes under the *Flex Plan*.

D. No Guarantee Of Tax Consequences

Neither the *Flex Plan Administrator* nor the *employer* makes any commitment or guarantee that any amounts paid to or for the benefit of a *covered person* under this *Flex Plan* will be excludable from the *covered person's* gross income for federal, state or local income tax purposes. It shall be the obligation of each *covered person* to determine whether each payment under this *Flex Plan* is excludable from the *covered person's* gross income for federal, state and local income tax purposes, and to notify the *Flex Plan Administrator* if the *covered person* has any reason to believe that such payment is not so excludable.

E. Non-Assignability Of Rights

The right of any *covered person* to receive any reimbursement under this *Flex Plan* shall not be alienable by the *covered person* by assignment or any other method and shall not be subject to *claims* by the *covered person's* creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

F. Headings

The headings of the various articles and sections are inserted for convenience of reference and are not to be regarded as part of this *Flex Plan* or as indicating or controlling the meaning or construction of any provision.

Article XI. Exclusions

A. Expenses That Are Not Reimbursable Under the *Health FSA Option*

The following expenses are not reimbursable, even if they meet the definition of “medical care” under *Code* § 213 (d) and of IRS Publication 502 and may otherwise be reimbursable under regulations governing *health FSAs*:

1. Health insurance premiums that *you* or *your spouse* pay for coverage under another health plan.
2. Long-term care services.
3. Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
4. The salary expense of a nurse to care for a healthy newborn at home.
5. Funeral and burial expenses.
6. Household, personal care and domestic help (even though recommended by a qualified physician due to a *covered employee’s* or *dependent’s* inability to perform physical housework).
7. Home or automobile improvements.
8. Costs for sending a child of special needs to a special school for benefits that the child may receive from the course of study and disciplinary methods.
9. Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
10. Bottled water.
11. Maternity clothes.
12. Diaper service or diapers.
13. Cosmetics, personal care expenses, toiletries, toothpaste, etc.
14. Uniforms or special clothing, such as maternity clothing.
15. Automobile insurance premiums.
16. Services that are determined not *medically necessary* by the *Flex Plan Administrator* or its designee.
17. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
18. Any item that does not constitute “medical care” as defined under *Code* § 213 (d).
19. Meals, food or beverages even if prescribed by a physician.
20. Any item that is not reimbursable under *Code* § 213 (d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.
21. Custodial care, except to the extent for nursing services provided by a licensed attendant, but in no case are household or personal care expenses covered.
22. Services or supplies that are not for the treatment of a medical condition but only to improve the *covered person’s* general health or appearance.
23. Massage therapy, unless prescribed by a physician for the treatment of a specific medical condition.
24. Health club or fitness program dues, unless prescribed by a physician for the treatment of a specific medical condition of the *covered person*.
25. Expenses for weight-loss programs or treatments, including drugs and medicines, unless prescribed by a physician and the programs or treatments are necessary to alleviate a specific medical condition, such as diabetes.
26. Vitamins and herbal or dietary food supplements, unless prescribed by a physician for the treatment of a specific medical condition
27. Transportation expenses of any sort, including transportation expenses to receive non-emergency medical care, unless primarily essential for the *covered person* to receive medical care.

28. Pregnancy testing kits.

NOTE: Over-the-counter medications (such as antacids, allergy and cold medications, aspirin and pain relievers), are reimbursable under the *health FSA* portion of this *Flex Plan*.

Article XII. Definitions

<i>Account(s)</i>	The <i>health FSA Accounts</i> and the <i>dependent care FSA Accounts</i> described in the Article entitled, “ <i>Health FSA Benefits</i> ”, the Article entitled, “ <i>Dependent Care FSA Benefit</i> , respectively.
<i>Annual Enrollment Period</i>	With respect to a <i>plan year</i> means such period as may be prescribed by the <i>Flex Plan Administrator</i> .
<i>Benefits</i>	The <i>premium payment benefits</i> , <i>health FSA benefits</i> and the <i>dependent care FSA benefits</i> offered under the <i>Flex Plan</i> .
<i>Benefit Package Option, Other Group Benefit Program, or Group Benefit Program</i>	A qualified benefit under <i>Code</i> Section 125 (f) that is offered under a cafeteria plan; or an option for coverage under an underlying accident or medical plan (such as an indemnity option, an HMO option, or a PPO option under an accident or medical plan).
<i>Change in Status</i>	Has the meaning described in Article entitled, “ <i>Premium Payment Benefits</i> ”, and in the Article entitled, “ <i>Election Change Events (Exceptions to Irrevocable Elections)</i> ”.
<i>Claim</i>	A request for <i>benefits</i> made by a <i>covered person</i> or his or her authorized representative in accordance with the applicable substantiation and filing procedures described in this <i>SPD</i> .
<i>COBRA</i>	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
<i>Code</i>	The Internal Revenue Code of 1986, as amended.
<i>Committee</i>	The benefits committee appointed by the Board of Directors of The College of St. Scholastica
<i>Compensation</i>	The wages or salary paid to a <i>covered employee</i> by the <i>employer</i> , determined prior to (a) any <i>salary reduction</i> election under this <i>Flex Plan</i> , (b) any <i>salary reduction</i> election under any other cafeteria plan, and (c) any compensation reduction under any <i>Code</i> Section 132(f)(4) plan; but determined after (d) any salary deferral elections under any <i>Code</i> Section 401(k), 403(b), 408(k) or 457(b) plan or arrangement. Thus, “ <i>Compensation</i> ” generally means wages or salary paid to a <i>covered employee</i> by the <i>employer</i> , as reported in the W-2 form, but adding back any wages or salary forgone by virtue of any election described in (a), (b) or (c) of the prior sentence.
<i>Continuous Coverage</i>	The maintenance of continuous and uninterrupted creditable coverage.
<i>Covered Employee</i>	A person who is an eligible employee and who is participating in this <i>Flex Plan</i> in accordance with the provisions of the Article, entitled, “ <i>Eligibility, Enrollment and Participation, Termination</i>

	and Leaves”. Covered employees include (a) those who elect one or more of the <i>premium payment benefits, health FSA benefits or dependent care FSA benefits, salary reductions</i> to pay for such <i>benefits</i> .
<i>Covered Person(s)</i>	The <i>covered employee</i> and his or her covered <i>spouse</i> and covered <i>dependents</i> .
<i>Creditable Coverage</i>	Means the health benefits or health coverage provided under any of the following: <ol style="list-style-type: none"> 1. coverage under group health plans (whether or not provided through an insurer); 2. Medicaid; 3. Medicare; 4. national health plans; 5. public health plans; as well as 6. all other types of coverage set forth in the Health Insurance Portability and Accountability Act of 1996 (<i>HIPAA</i>).
<i>Dependent</i>	Means, with respect to an applicable <i>group benefit program</i> , any individual who qualifies as a dependent under the applicable certificate of coverage, contract or summary plan description documents for such program, and with respect to <i>health FSA benefits</i> , shall mean: <ol style="list-style-type: none"> 1. lawful <i>spouse</i>. 2. unmarried children, from birth through age 18, including: <ol style="list-style-type: none"> a. natural children; b. legally adopted children or children placed with <i>you</i> for legal adoption (date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligation of total or partial support.); c. stepchildren; d. a child who is under the age of 19 and for whom <i>you</i> have been appointed legal guardian by a court of law; e. a child covered under a valid Qualified Medical Child Support Order (QMCSO), as defined under Section 609 of the Employee Retirement Income Security Act (<i>ERISA</i>) and its implementing regulations, which is enforceable against a <i>covered employee</i>. Contact the <i>Flex Plan Administrator</i> for assistance in obtaining information, at no cost to <i>you</i>, regarding the procedures governing QMCSO determinations. The <i>Flex Plan Administrator</i> is responsible for determining whether or not a medical child support order is a valid QMCSO. 3. Unmarried dependent children from age 19 through age 24 who are enrolled as students in regular full-time attendance at an accredited secondary or post-secondary educational

	<p>institution, which is an accredited high school, university, four-year college, community college, technical school, or vocational school. In order to qualify as an eligible dependent under this provision, the student must carry the required number of credits per quarter/semester to qualify as a full-time student, as defined by the educational institution. A regularly scheduled break in classes, such as summer break or j-term, will not affect a student's full-time status as long as the student returns to school when the scheduled break ends.</p> <p>A student, who by reason of sickness, injury or physical or mental disability documented by a physician and approved by the <i>Flex Plan Administrator</i> or its designee, shall remain eligible if the student's course load is at least 60% of what is otherwise considered to be full-time by the educational institution.</p> <p>For purposes of this <i>SPD</i>, a student's address is considered to be the same as <i>your</i> address when attending an accredited school on a full-time basis.</p> <p>4. Unmarried handicapped dependent children, after reaching the age of 19, will remain eligible for coverage provided they are:</p> <ol style="list-style-type: none"> a. Incapable of self-sustaining employment, because of physical handicap, mental retardation, mental illness, or mental health disorder; and b. Dependent on the <i>covered employee</i> for a majority of financial support and maintenance; and c. Became handicapped before age 19 or became handicapped after age 18 but before age 25 and while a full-time student covered as a dependent of the <i>covered employee</i>. <p>Application for extended coverage and proof of incapacity must be furnished to the <i>Flex Plan Administrator</i> within 31 calendar days after the <i>dependent</i> reaches age 19 or becomes handicapped while covered as a full-time student. After this initial proof, the <i>Flex Plan Administrator</i> may request proof again two years later, and each year after.</p> <p>A handicapped covered dependent will be eligible for coverage as long as he or she continues to be handicapped and dependent on the <i>covered employee</i>, unless coverage otherwise terminates under this <i>Flex Plan</i>.</p>
<i>Dependent Care Expenses</i>	Has the meaning defined in the Article entitled, " <i>Dependent Care FSA Benefit</i> ".
<i>Dependent Care FSA Account</i>	Means the <i>Account</i> described in the Article entitled, " <i>Dependent Care FSA Benefit</i> ".

<i>Dependent Care FSA and Dependent Care FSA Benefits</i>	Has the meaning described in the Article entitled, “ <i>Dependent Care FSA Benefit</i> ”.
<i>Earned Income</i>	Has the meaning described in the Article entitled, “ <i>Dependent Care FSA Benefit</i> ”.
<i>Election Form/Salary Reduction Agreement</i>	The form provided by the <i>Flex Plan Administrator</i> for the purpose of allowing a <i>covered employee</i> to participate in this <i>Flex Plan</i> by electing <i>salary reductions</i> to pay for any of the following: <i>health FSA benefits</i> , and <i>dependent care FSA benefits</i> . It includes an agreement pursuant to which a <i>covered employee</i> authorizes the <i>employer</i> to make <i>salary reductions</i> and or deductions from compensation.
<i>Employee Contribution</i>	The amount the <i>covered employee</i> provides toward the cost of <i>benefits</i> through the <i>employer</i> benefit plan(s).
<i>Employer</i>	The College of St. Scholastica that adopts this <i>Flex Plan</i> .
<i>Employer Contribution</i>	The amount, if any, the <i>employer</i> provides toward the cost of <i>benefits</i> through the <i>employer</i> benefit plan(s) for <i>covered employees</i> .
<i>Enrollment Date</i>	The date of enrollment in the <i>Flex Plan</i> or, the first day of the waiting period for enrollment under this <i>Flex Plan</i> .
<i>ERISA</i>	The Employee Retirement Income Security Act of 1974, as amended.
<i>Flex Plan</i>	The College of St. Scholastica Flexible Spending Plan as set forth herein and as amended from time to time.
<i>Flex Plan Administrator</i>	The College of St. Scholastica. The contact person is the Human Resources Manager for The College of St. Scholastica, who has the full authority to act on behalf of the <i>Flex Plan Administrator</i> , except with respect to appeals, for which the <i>Committee</i> has the full authority to act on behalf of the <i>Flex Plan Administrator</i> .
<i>Flex Plan Sponsor</i>	The <i>employer</i> that has established and maintains this <i>Flex Plan</i> .
<i>FMLA</i>	The Family and Medical Leave Act of 1993, as amended.
<i>FSA benefits</i>	<i>Health FSA benefits</i> and <i>dependent care FSA benefits</i> , collectively.
<i>Grace Period(s)</i>	The period that begins immediately after the close of a <i>plan year</i> and ends on the day that is two months plus 15 calendar days after the close of that <i>plan year</i> and to be reimbursed for those expenses with any remaining account balance from the prior plan year.

<i>Health FSA and Health FSA benefits</i>	Has the meaning as set forth in the Article entitled, " <i>Health FSA Benefits</i> ".
<i>Health FSA Account</i>	The <i>account</i> described in the Article entitled, " <i>Health FSA Benefits</i> ".
<i>HIPAA</i>	The Health Insurance Portability and Accountability Act of 1996, as amended.
<i>Incurred</i>	Services and supplies rendered to <i>you</i> . Such expenses shall be considered to have been <i>incurred</i> at the time or date the service or supply was actually purchased or provided.
<i>Medically Necessary</i>	Diagnostic testing, preventive health care services, and medical treatment consistent with the diagnosis of a prescribed course of treatment for member's condition, which the <i>Flex Plan Administrator</i> or its designee determines and will use its discretion on a case-by-case basis are consistent with the medical standards and accepted practice parameters of the community and considered necessary for the <i>covered person's</i> condition; and <ol style="list-style-type: none"> 1. help to restore or maintain <i>covered person's</i> health; or 2. prevent deterioration of <i>covered person's</i> condition; or 3. prevent the reasonably likely onset of a health problem or detect a problem that has no or minimal symptoms.
<i>Medical Care Expenses</i>	Has the meaning defined in the Article entitle, " <i>Health FSA Benefits</i> ".
<i>Period of Coverage</i>	The <i>plan year</i> , with the following exceptions: (a) for <i>covered employees</i> who first become eligible to participate, it shall mean the portion of the <i>plan year</i> following the date participation commences, as described in the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves", and (b) for <i>covered employees</i> who terminate participation, it shall mean the portion of the <i>plan year</i> prior to the date participation terminates, as described in the Article entitled, "Eligibility, Enrollment and Participation, Termination and Leaves".
<i>Plan Year</i>	The year (i.e., the 12-month period) commencing on January 1 and ending on December 31 of each year, except in the case of a short <i>plan year</i> representing the initial <i>plan year</i> or where the <i>plan year</i> is being changed, in which case the <i>plan year</i> shall be the entire short <i>plan year</i> .
<i>Premium</i>	The amount contributed to pay for the cost of <i>benefits</i> (including those that are self-insured).
<i>Premium Payment Benefits</i>	The premium payment benefits described in the Article entitled, " <i>Premium Payment Benefits</i> ".

<i>Premium Payment Component</i>	The component of this <i>Flex Plan</i> described in the Article entitled, “ <i>Premium Payment Benefits</i> ”.
<i>Prior Plan Year Health FSA Amounts</i>	The amounts described in Article IV.D.5., “ <i>Grace Periods; Rules for Expenses Incurred during a Grace Period.</i> ”
<i>Qualified Benefit</i>	Any benefit excluded from the <i>covered employee’s</i> taxable income under Chapter 1 of the <i>Code</i> (other than benefits excluded under <i>Code</i> Sections 106(b), 117, 127, or 132) and any other benefit permitted by regulations under the <i>Code</i> (i.e., any group-term life insurance coverage that is includible in gross income by reason of exceeding the dollar limitation on non-taxable coverage under <i>Code</i> Section 79). Long-term care insurance shall not be a qualified benefit.
<i>Qualifying Dependent Care Services</i>	Has the meaning described in the Article entitled, “ <i>Dependent Care FSA Benefit</i> ”.
<i>Qualifying Individual</i>	Has the meaning described in the Article entitled, “ <i>Dependent Care FSA Benefit</i> ”.
<i>Salary Reduction</i>	The amount by which the <i>covered employee’s</i> compensation is reduced and applied by the <i>employer</i> under this <i>Flex Plan</i> to pay for one or more of the <i>benefits</i> , as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the <i>covered employee’s</i> compensation (i.e., on a pre-tax basis).
<i>Spouse</i>	Means, with respect to an applicable <i>group benefit program</i> , any individual who qualifies as your legal spouse under the applicable certificate of coverage, contract or summary plan description for such program, and with respect to <i>health FSA benefits</i> shall mean a person who is <i>your</i> lawful <i>spouse</i> (as defined under Minnesota Statute Section 517.01) of the opposite sex and will not include a common law <i>spouse</i> regardless if recognized under Minnesota or other state or country law.
<i>Summary Plan Description (SPD)</i>	The document describing, among other things, the <i>benefits</i> offered under this <i>Flex Plan</i> and <i>your</i> rights and obligations under such benefit option as required by <i>ERISA</i> .
<i>Third Party Administrator or PreferredOne</i>	PreferredOne Administrative Services, Inc.
<i>You/Your</i>	Refers to <i>covered employee</i> , <i>covered dependent</i> or <i>covered person</i> .

Article XIII. FLEX PLAN ADMINISTRATION INFORMATION

The Employee Retirement Income Security Act (*ERISA*) requires that certain information be furnished to each *covered employee* under the *health FSA* portion of the *Flex Plan*. This *Flex Plan* administration information supplements the *Summary Plan Description* and only applies to the *health FSA*.

Flex Plan Name: The College of St. Scholastica
Flexible Spending Plan

Flex Plan Address: 1200 Kenwood Avenue
Duluth, MN 55811

Plan Effective Date: October 1, 2004, restated January 1, 2008

**Employer; Flex Plan Administrator;
Flex Plan Sponsor; and Named
Fiduciary for Health FSA benefits** The College of St. Scholastica
1200 Kenwood Avenue
Duluth, MN 55811
Telephone: 218.723.5954

Employer Identification Number(EIN): 41-0698301

Plan Identification Number (PIN): 634 Note: This number differs from the *employer's*
separate medical plan.

Type of Plan: Code Section 125 "Cafeteria Plan", which includes
premium payment benefits, (pre-tax deduction towards
premiums), *health FSA benefits* (a self-insured medical
reimbursement plan under Code Section 105) and
dependent care FSA benefits under Code Section 129. The
health FSA is also an employee welfare benefit plan.

Third Party Administrator (TPA): PreferredOne Administrative Services, Inc.
6105 Golden Valley Road
Minneapolis, MN 55459-0052
Telephone: 763-847-4477

Plan Year: A 12-month period beginning each January 1st and ending
December 31 of that year.

Funding: This is a self-insured plan, not insured by the *TPA*;
therefore the *employer* and the employee fund the *Flex
Plan* to pay *Claims*.