

CAFETERIA PLAN

INCLUDING,

WHERE APPLICABLE,

DEPENDENT CARE ASSISTANCE PLAN,

MEDICAL REIMBURSEMENT PLAN,

INDIVIDUAL BILLED MEDICAL PREMIUM PLAN,

GROUP INSURANCE PREMIUM PLAN,

HSA CONTRIBUTION OPTION, AND

COVERAGE WAIVER CASH OPTION PLAN

OF

("Employer")

**COMBINED
SUMMARY PLAN DESCRIPTION**

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I. INTRODUCTION

This document (the "Summary") summarizes the Cafeteria Plan and related plans. The Cafeteria Plan is made up of one or more of the following: Dependent Care Assistance Plan, Medical Reimbursement Plan, Group Insurance Premium Plan, Dependent Care Assistance Plan, Individual Billed Medical Premium Plan, HSA Contribution Option, and Coverage Waiver Cash Option Plan (collectively referred to as the "Benefit Plans" and together with the Cafeteria Plan referred to as the "Plans"). The Dependent Care Assistance Plan and Medical Reimbursement Plan are sometimes referred to as "Reimbursement Plans." The Plans operate on a year-to-year basis or "Plan Year." Each Plan Year is from January 1 to December 31. Except as noted, this Summary describes the Plans as of January 1, 2009, unless otherwise provided here: _____
[Employer: Insert general effective date if different than January 1, 2009] (the "Effective Date").

Although this Summary will give you a general understanding of how the Plans work, it is only an overview. The detailed legal documents under which the Plans are established, and not this Summary (or any forms or other materials provided by the Employer or third party administrator) control your rights and shall be controlling if the documents for the Plans and this overview conflict in any respect. Copies of the legal documents are available for your review at the offices of the Employer.

It is intended that the Plans comply with current Federal laws. If the laws change the Plans may be changed.

II. GENERAL PROVISIONS

A. GENERAL INFORMATION

The Plan Sponsor, Plan Administrator and agent for service of legal process, Plan Year, type of administration, and source of contributions are the same for all the Plans. Common information on the Plans is listed below.

PLAN SPONSOR/EMPLOYER:

NAME: _____

ADDRESS: _____

EMPLOYER I.D. NUMBER: _____

TELEPHONE NUMBER: _____

Related Employers, if any, also sponsoring the plans are attached on Exhibit A. The term "Employer" includes the Plan Sponsor named above and any Related Employer, except that

generally only the Employer named above (i) shall serve as Plan Administrator and (ii) shall have the right to amend and terminate the Plan.

PLAN ADMINISTRATOR, NAMED FIDUCIARY, AGENT FOR SERVICE OF LEGAL PROCESS:

NAME: Plan Sponsor, unless otherwise noted here:

ADDRESS: Same as Plan Sponsor, unless otherwise noted here:

TELEPHONE NUMBER: Same as Plan Sponsor, unless otherwise noted here:

Service of Legal Process may be made upon the Plan Administrator.

TYPE OF PLAN: To the extent that any of the Plans provide medical care as defined by Federal law, these are group health plans (a type of welfare plan that is subject to the provisions of ERISA). For more information about "Type of Plan," see below.

PLAN YEAR: Unless otherwise provided, the Plans' financial and other records are maintained on the basis of a "Plan Year" which is the year beginning each January 1 and ending each December 31.

SOURCE OF CONTRIBUTIONS TO THE PLAN: Employee salary reduction contributions except as otherwise noted.

TYPE OF ADMINISTRATION: Combination of third party contract administration by WATDA Services, Inc. ("WATDASI") and self-administration by the Plan Administrator. WATDASI is a third party administrator located at 150 East Gilman Street, Suite A, Madison, WI 53703, which provides administrative services with respect to the Plans. WATDASI is not a fiduciary under any of the Plans.

FINANCING OR ADMINISTRATION BY A HEALTH INSURANCE ISSUER: None of the benefits under the Plans are guaranteed under a contract or policy of insurance issued by a health insurance issuer, but the underlying plans or policies may be. Refer to the underlying plans or policies for more detail regarding the involvement of a health insurance issuer in those plans or policies.

COLLECTIVELY BARGAINING INFORMATION: If the following box is checked [], one or more of the Plans are maintained pursuant to one or more collective bargaining agreements, and a copy of the collective bargaining agreement may be obtained upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries as required by Employee Benefits Security Administration Regulations Sections 2520.104b-1 and 2520.104b-30.

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1. NAME OF PLAN: **Cafeteria Plan**
PLAN NUMBER: 513 (unless stated otherwise here: _____)
TYPE OF PLAN: Cafeteria plan under Internal Revenue Code of 1986 ("Code") Section 125. To the extent that any of the Plans provide medical care as defined by Federal law, these are group health plans (a type of welfare plan that is subject to the provisions of ERISA).
BENEFITS AVAILABLE UNDER THE CAFETERIA PLAN: Benefits are available under the Cafeteria Plan from the Benefit Plans checked below:
 Group Insurance Premium Plan (also fill out Section II.A.2 below), which includes the following Employer-sponsored Premium Plan(s):
 Health (health and/or dental) Plan(s);
 Long-Term Disability Plan(s);
 Short-Term Disability Plan(s);
 Group Term Life Plan(s).
 Dependent Care Assistance Plan (also fill out Section II.A.3, below).
 Medical Reimbursement Plan (also fill out Section II.A.4, below).
 Individual Billed Medical Premium Plan (also fill out Section II.A.5, below).
 HSA Contribution Option (also fill out Section II.A.6, below).
 Coverage Waiver Cash Option Plan (also fill out Section II.A.7, below).
MAXIMUM AMOUNT AVAILABLE UNDER THE CAFETERIA PLAN: The maximum amount of benefits that a participant may receive under the Cafeteria Plan in any Plan Year is equal to the sum of the maximum amounts of benefits under the individual Benefit Plans provided by the Employer.
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2. NAME OF PLAN (if applicable; see Section II.A.1, above): **Group Insurance Premium Plan**
PLAN NUMBER: 510 (unless stated otherwise here: _____).
TYPE OF PLAN: Underlying accident or health care plan under Code Section 105 or 106, disability plan and/or group term life insurance plan under Code Section 79.
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3. NAME OF PLAN (if applicable; see Section II.A.1, above): **Dependent Care Assistance Plan**
PLAN NUMBER: 512 (unless stated otherwise here: _____)
TYPE OF PLAN: Dependent care assistance plan under Code Section 129.
MAXIMUM REIMBURSEMENT AMOUNT: \$ _____.
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4. NAME OF PLAN (if applicable; see Section II.A.1, above): **Medical Reimbursement Plan**
PLAN NUMBER: 511 (unless stated otherwise here: _____)
TYPE OF PLAN: Medical reimbursement plan under Code Section 105.
MAXIMUM REIMBURSABLE AMOUNT: \$ _____.

ALLOWABLE EXPENSES: This Plan shall allow for Qualifying Medical Care Expenses as provided in this Summary, unless checked here: . (If checked, only Limited Expenses shall be allowed (dental and vision expenses and no over-the-counter drugs).)

GRACE PERIOD: This Medical Reimbursement Plan shall provide for a Grace Period as provided in this Summary unless checked here: . (If checked, no Grace Period is applicable with respect to Plan Years starting on or after the Effective Date, or such other date provided here: _____).

5. NAME OF PLAN *(if applicable; see Section II.A.1, above)*: **Individual Billed Medical Premium Plan**

PLAN NUMBER: 514 (unless stated otherwise here: _____).

TYPE OF PLAN: Accident or health plan under Code Section 105 or 106.

6. NAME OF PROGRAM *(if applicable; see Section II.A.1, above)*: **HSA Contribution Option**

The HSA Contribution Option is not an employee benefit plan but instead is a funding feature for health savings accounts under Code Section 223.

7. NAME OF PLAN *(if applicable; see Section II.A.1, above)*: **Coverage Waiver Cash Option Plan**

PLAN NUMBER: 515 (unless stated otherwise here: _____).

TYPE OF PLAN: Accident or health plan under Code Section 105 or 106.

B. THE VALUE OF THE PLANS

The purpose of the **Cafeteria Plan** is to allow you, if you are an eligible employee, to obtain certain benefits from pre-tax dollars (except for the Coverage Waiver Cash Option Plan which allows an eligible person to receive additional taxable cash compensation instead of health insurance). This is done by giving you the right to have the Employer withhold some of your regular compensation and use it to pay those benefits. By doing this, you will not be taxed on the portion of your compensation used to pay the benefits. This generally is true for purposes of both Federal and Wisconsin income taxes. In addition, that portion of compensation will not be subject to any Employer or employee Social Security tax to which it otherwise would have been subject. Note that this could have an impact on the Social Security benefits that you will be entitled to receive some day.

THE FOLLOWING INFORMATION ON SPECIFIC BENEFIT PLANS APPLIES ONLY IF THE BOX FOR THAT BENEFIT PLAN IS CHECKED IN SECTION II.A ABOVE.

- If the box for "**Group Insurance Premium Plan**" is checked in Section II.A above, this means that the Cafeteria Plan allows you to pay your share of premiums for the Employer-sponsored group insurance plans (Health (which may include dental), Long-Term Disability, Short-Term Disability and Group Term Life Plans, as applicable) with pre-tax dollars. This Summary does not cover these underlying plans except with respect to elections under the Cafeteria Plan. See the Plan Administrator of these underlying plans for information concerning eligibility and other terms of these plans.
- If the box for the **Medical Reimbursement Plan** and/or the **Dependent Care Assistance Plan** is checked in Section II.A above, this means that the Cafeteria Plan allows you to obtain reimbursement for medical expenses and/or dependent care expenses up to a specified amount from pre-tax dollars.
- If the box for **Individual Billed Medical Premium Plan** is checked in Section II.A above, this means that the Cafeteria Plan allows you to pay or to obtain reimbursement for premiums paid under an individual health insurance policy from pre-tax dollars. This Summary does not cover the underlying policy except with respect to elections under the Cafeteria Plan. See your individual policy for eligibility and other terms.
- If the box for the **HSA Contribution Option** is checked in Section II.A above, this means that the Cafeteria Plan allows you to fund a Code Section 223 health savings account with pre-tax dollars. Note that health savings accounts have their own restrictions and requirements and are set up through a separate trustee or custodian. This Summary does not cover the health savings account except with respect to elections under the Cafeteria Plan. See the trustee or custodian of your health savings account for information concerning eligibility and other terms of your health savings account.
- If the box for **Coverage Waiver Cash Option Plan** is checked in Section II.A above, this means that the Cafeteria Plan allows you to waive health plan coverage and receive taxable compensation if you are covered under another health insurance plan not sponsored by the Employer.

C. ELIGIBILITY TO PARTICIPATE

1. Who may participate in the Plans?

If you are an employee, you are eligible to participate in the Cafeteria Plan if you customarily work at least 20 hours per week (unless another hour per week amount is entered here: _____), excluding overtime. Individuals with Employers offering or individuals participating in a Health Savings

Account (See Questions and Answers IV.II and IV.12.) may participate to a limited extent with respect to the Medical Reimbursement Plan and may participate in the HSA Contribution Option. Certain leased employees, self-employed individuals, and independent contractors are not considered employees and are not eligible to participate. Regardless of whether you meet the specified eligibility criteria, in certain circumstances you also may become a participant as of the first day of the Plan Year beginning after you complete 3 years of employment with the Employer, in accordance with procedures established by the Plan Administrator. Please see the Plan Administrator if you need more details.

Check the questions and answers below for each Benefit Plan to see whether you are eligible to participate in that Plan. Eligibility for the Medical Reimbursement Plan or the Dependent Care Assistance Plan will not automatically make you eligible for the Insurance Premium Plan, or vice versa; you must meet the eligibility requirements for a specific Plan to participate in that Plan.

2. What are the eligibility rules for the Medical Reimbursement Plan and Dependent Care Assistance Plan?

If you meet the requirements of Question and Answer II.C.1 immediately above, you also are eligible for the Medical Reimbursement Plan and Dependent Care Assistance Plan.

3. What are the eligibility rules for the Group Insurance Premium Plan or Individual Billed Medical Premium Plan?

To be eligible for the Group Insurance Premium Plan or Individual Billed Medical Premium Plan (if offered), you must meet the Cafeteria Plan requirements and be eligible for one or more of the Employer's health plans in accordance with procedures established by the Plan Administrator.

Plans that are covered under the Group Insurance Premium Plan sometimes are called "Premium Plans." The Employer will notify you as to which plans are covered by the Group Insurance Premium Plan.

You will become a participant in the Group Insurance Premium Plan or Individual Billed Medical Premium Plan, as applicable, upon the effective date on which you become eligible to participate in one or more of the Employer's health plans covered by the Group Insurance Premium Plan or policies covered by the Individual Billed Medical Premium Plan, if applicable, in accordance with procedures established by the Plan Administrator.

4. When am I considered a participant and when do I receive benefits?

You are considered a participant as of the first date that an election to receive benefits could be made effective. Participants include those who elect to receive benefits and those who are deemed to have elected not to receive benefits, but rather to receive their normal cash compensation instead. A participant may receive benefits from a Benefit Plan under the Cafeteria Plan when the participant

- (a) meets the requirements for that Benefit Plan (and underlying Premium Plan, if applicable) and
- (b) elects in accordance with the Cafeteria Plan to receive benefits under the Benefit Plan.

5. What happens if I cease to be eligible?

If you cease to be eligible, your participation in the Plans generally will cease. For additional information, please see the Section VII.A.

6. What are the rules for HIPAA special enrollments?

If you do not elect to enroll yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Cafeteria Plan and certain Benefit Plans, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. "HIPAA" is a law that only applies to certain types of benefits. For more information on when HIPAA applies, please see the Questions and Answers on HIPAA in Section VII.E.

7. What are the benefits for adopted children?

With respect to component benefits that are group health plans, as required by law, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children.

8. Are there preexisting condition exclusions under the Plans?

No. The Plans have no preexisting condition exclusion; however, the benefits offered by the underlying health plans or policies covered by the Group Insurance Premium Plan or Individual Billed Medical Premium Plan may or may not have such provisions. Please refer to those plans for information as to whether those benefits are subject to any preexisting condition exclusions.

9. What are the eligibility rules for the HSA Contribution Option?

To be eligible for the HSA Contribution Option, you must be an "HSA-Eligible Individual," enrolled in a "High Deductible Health Plan" sponsored by the Employer, submit a certificate of HSA-Eligible Individual status in such form as the Plan Administrator may prescribe and, with respect to any pre-tax contributions to an HSA you wish to make, complete an election form indicating the amount of election.

An "HSA-Eligible Individual" is an individual who (a) is eligible under Code Section 223 to contribute to a health savings account, (b) has elected qualifying High Deductible Health Plan coverage offered by the Employer, and (c) is **not** covered under any disqualifying non-High

Deductible Health Plan health plan. A "High Deductible Health Plan" is a health plan that meets the requirements of a high deductible health plan under Code Section 223(c)(2).

10. What are the eligibility rules for the Coverage Waiver Cash Option Plan?

To be eligible for the Coverage Waiver Cash Option Plan, you must meet the Cafeteria Plan requirements, be eligible for one or more of the Employer's health plans in accordance with procedures established by the Plan Administrator and have health insurance coverage under a plan not sponsored by the Employer.

D. ELECTION TO RECEIVE BENEFITS UNDER THE PLANS (SIGNING UP)

An eligible employee will become a participant in the Cafeteria Plan or a Benefit Plan upon the first date that his or her election could be made effective under the applicable plan. An election to reduce salary and receive benefits in one or more of the Benefit Plans is done through an election form and compensation reduction agreement which must be filed with the Plan Administrator within the time period set by the Plan Administrator. The Plan Administrator of the Cafeteria and Benefit Plans will make election forms available when you first become eligible (for those newly eligible) or during an open enrollment period held before the beginning of each Plan Year (for all eligible employees). The election form will be effective as of the first day of the next pay period following the date the election form is submitted to the Plan Administrator.

If you do not return a completed election form to the Plan Administrator by the due date for the first Plan Year in which you could become a participant, you still will be considered to be a participant, but you will be deemed to have elected to receive your normal cash compensation (with respect to the Coverage Waiver Cash Option Plan, you will be deemed not to have waived health coverage). If you do not return a completed election form to the Plan Administrator by the due date for any later Plan Year, you will be deemed (1) to have made the same election with respect to the Group Insurance Premium Plan or Individual Billed Medical Premium Plan as was in effect for the prior Plan Year, (2) to have elected cash compensation rather than salary reduction and benefits under the Reimbursement Plans and HSA Contribution Option, and (3) not to have waived health plan coverage under the Coverage Waiver Cash Option Plan.

The amount you elect (or are deemed to have elected) for each type of benefit **may not** be used for another benefit. For example, the amount you elect to reduce your compensation to provide dependent care assistance reimbursements may not be used to provide medical reimbursements, even if you elected to contribute "too much" for the Dependent Care Assistance Plan and "too little" for the Medical Reimbursement Plan.

Each participant shall sign documents and provide the Employer and Plan Administrator with information and evidence as may reasonably be requested to administer the Plans.

E. PLAN ACCOUNTING

The amounts you are required to pay for insurance coverage under an Employer-sponsored health or dental plan or individual policy covered under the Group Insurance Premium Plan automatically will determine the amount of pay you will have reduced for participation in the Group Insurance Premium Plan or Individual Billed Medical Premium Plan, respectively. These amounts will be paid directly to the insurer (or other entity to the extent allowed by the Plan) or, in the case of the Individual Billed Medical Premium Plan if (1) the Plan Administrator permits reimbursements and (2) you have properly substantiated your expenses and completed the reimbursement forms, will be reimbursed to you after you have paid the premium.

Any amounts you elect to contribute for medical reimbursement and/or dependent care assistance will be credited to Accounts established for you. You can draw upon those Accounts during the Plan Year to provide reimbursements to you for the covered expenses you incur during the Plan Year Coverage Period (or Grace Period, if applicable, only for those Medical Reimbursement Plans with a Grace Period (see Section II.A.4)).

Accounts are for bookkeeping purposes only. No specific assets are set aside for any participant. A participant is a general creditor of the Employer with unsecured rights to benefits from the Plan. The right of a participant to participate in the Plans may not be pledged or assigned. The Employer and the Plan Administrator make no guarantee as to the tax consequences of the Plans.

Any amounts you elect to contribute to a health savings account will be forwarded to the trustee or custodian of the health savings account. The trustee or custodian, not the Plan Administrator, shall be responsible for the accounting of your health savings account. The Plan Administrator may limit the trustees or custodians to which such contributions will be made.

F. ADVANTAGE OF PARTICIPATING

Participating in the Plans allows you to save money by paying certain expenses with pre-tax money rather than after-tax money. For example, assume that a participant named Sue has \$1,000 of health coverage payments required during the Plan Year and that her income tax rate (combined state and Federal) is 25%, and that all of her pay is subject to FICA taxes.¹

¹*Warning:* The rates and numbers used in this example are **estimates** only for illustrative purposes. More accurate calculations are needed to determine the tax impact on your situation. For example, your income tax rate may be different and the FICA tax rate of 7.65% which was effective for 2009 in this example could be less depending upon your income.

If Sue does not elect benefits under the Group Insurance Premium Plan (for example, if Sue chose coverage under a non-employer-sponsored plan), Sue has to earn \$1,484.78 to have enough money after taxes to pay her \$1,000 cost of health care coverage. Out of her \$1,484.78, Sue first pays FICA tax and income tax, leaving her with just enough to pay her \$1,000 of health coverage cost.

Earnings	\$1,484.78
FICA tax (\$1,484.78 x 7.65%)	113.58
Income tax (\$1,484.78 x 25%)	<u>371.20</u>
Amount remaining to pay health coverage cost	\$1,000.00

In contrast, if Sue elects to receive benefits under the Group Insurance Premium Plan, then Sue has her taxable compensation reduced so that over the year a total of \$1,000 will be deducted to pay for her coverage. The same \$1,000 of coverage expense that Sue incurred is now paid through the Plan.

Sue could have elected to receive the \$1,000 in cash (and pay taxes on it) instead of applying it to pay for her share of health coverage (if, for example, she chose health coverage under a non-employer-sponsored health plan). **However, by electing to use the Plan to pay her cost, she does not pay taxes on the \$1,000.** Compare this with the amount she would have had to earn without the Plan (\$1,484.78) to pay for \$1,000 of after-tax coverage. As a result, Sue saves \$484.78 (pre-tax dollars) by receiving benefits under the Plan. After taxes, this amounts to a savings of \$326.49:

Earnings	\$1,484.78
Amount contributed to plan	<u>1,000.00</u>
Pre-tax dollars saved	484.78
FICA tax (\$484.78 x 7.65%)	37.09
Income tax (\$484.78 x 25%)	<u>121.20</u>
After-tax dollars saved	\$ 326.49

Another way to calculate the approximate after-tax savings is to multiply your contribution amount by your effective tax bracket. In this example, Sue's effective tax bracket is 32.65% (7.65% FICA + 25% income). Her after tax savings is $\$1,000.00 \times 32.65\% = \326.50 . (Rounding adjustments lead to the small difference in the two results.)

Let's look at another example by comparing John's situation if he receives benefits under the Medical Reimbursement Plan versus if he does not receive such benefits.

Without the Plan

Assume John is an eligible employee who has incurred \$200 of medical expenses during the Plan Year that were not covered by the Employer's health care plan. Assume also that his income tax rate (combined state and Federal) is 25%, and that all of his pay is subject to FICA taxes.

John has to earn \$296.96 to have enough left after taxes to pay his \$200 of medical expenses. Out

of his \$296.96, John first pays FICA tax and income tax, leaving him with just enough to pay his \$200 of medical expenses.

Earnings	\$296.96
FICA tax (\$296.96 x 7.65%)	22.72
Income tax (\$296.96 x 25 %)	<u>74.24</u>
After-tax amount left to pay medical expenses	\$200.00

With the Plan

Assume John elects to have his salary reduced so that a total of \$200 is credited to his Medical Reimbursement Account over the Plan Year. By electing to have the \$200 credited to his Account, he does not pay taxes on the \$200 yet has enough in the Plan to pay his medical expenses. As a result, John saves the taxes he would have been required to pay -- (\$96.96 pre-tax dollars, \$65.30 after-tax dollars) -- by electing to receive benefits under the Plan.

Earnings	\$296.96
Amount contributed to plan	<u>200.00</u>
Pre-tax dollars saved that would have been paid in taxes	\$ 96.96
FICA tax (\$96.96 x 7.65%)	7.42
Income tax (\$96.96 x 25 %)	<u>24.24</u>
After-tax dollars saved	\$ 65.30

Your actual savings under the Plans will depend on: (1) the amount of your reimbursable expenses and whether you use all of the amount credited to the Plans; (2) your marginal income tax rate; (3) whether you already have paid the maximum FICA taxes; and (4) whether an administrative fee is charged to pay for the cost of administering the Reimbursement Plans.

G. TIMING, IRREVOCABILITY AND IMPORTANCE OF ELECTIONS

With respect to the Group Insurance Premium Plan and Individual Billed Medical Premium Plan, the initial election you make will continue in effect for subsequent Plan Years until you revoke or modify such election. With respect to the Medical Reimbursement Plan, Dependent Care Assistance Plan, HSA Contribution Option, and Coverage Waiver Cash Option Plan, you will need to make a new written election prior to each Plan Year.

The Plan Administrator will announce deadlines by which you must make your annual elections to receive benefits under the Plans. You will be required to file your written election for each upcoming Plan Year by the deadline set by the Plan Administrator, which will be no later than the beginning of the first pay period of the upcoming Plan Year. Your pay then will be reduced in accordance with your election throughout the Plan Year. However, if you first become eligible to participate during the Plan Year, you may elect to receive benefits by filing a written election on or before the date

specified by the Plan Administrator which date shall be no later than the beginning of the first pay period for which your election agreement will apply. In this case, your pay will be reduced for pay periods beginning after the effective date of your election.

After the election period has passed, you generally **cannot change** your election for the Plan Year. The amount of your compensation reduction will not be revised to reflect any change during the Plan Year other than a permissible change discussed elsewhere in this Summary. If a change is made in your Benefit Plan election so that the amount of compensation reduction is greater than needed to pay for the elected benefits, you will forfeit the excess compensation reduction amount. There are some exceptions for certain permissible mid-year changes, as discussed in Section II.H, and for certain family and medical and uniformed services leaves, discussed in Section VII.

It is important to estimate carefully the amount of dependent care and medical expenses for which you will need reimbursement during the year. As discussed in Sections IV and V, any compensation which you contribute to the Plans but which you do not use to reimburse yourself for qualifying expenses **will be forfeited** permanently.

There are certain rules and limitations required by law which apply to the Plans. If the Plan Administrator determines that the Plans may fail to satisfy these rules or limitations, the Plan Administrator in its discretion may make a change to your election without your consent.

H. MID-YEAR CHANGE IN ELECTIONS

Although the general rule is that you cannot change your elections under the Plan or vary the salary reduction amount you have selected during the Plan Year, there are several important exceptions to this rule. As set forth more fully below, a mid-year change in election may be possible if certain events occur. Any change, including, but not limited to, determining the effective date of the change, is subject to administrative requirements and completion of forms, as determined by the Plan Administrator. **The HSA Contribution Option and Coverage Waiver Cash Option Plan are not subject to the change in status rules below; see instead Question and Answer 9 below for the HSA Contribution Option rules and Question and Answer 10 for the Coverage Waiver Cash Option Plan rules.**

1. What is the impact of a "change in status" on my elections?

If you have a "change in status," a change in your election may be possible if:

- The election change meets the "consistency" rules; and
- You make the request for an election change in writing within 30 days after the date of the change in status.

2. What is a "change in status"?

A "change in status" is:

- Your marriage, divorce, legal separation, or annulment;

Note: A "legal separation" generally does not refer to living separately in anticipation of divorce. Some states recognize legal separation as a separate marital status; Wisconsin is one of those states. You must meet the requirements for legal separation under the laws in your state in order to claim a change in status based on legal separation. In Wisconsin, this means you must have filed an action for separation and the court must have issued a legal separation decree, dividing and allocating any and all property, awarding custody and placement of minor children, if applicable, and awarding support, if applicable.

- Death of your spouse or your dependent;
- Birth, adoption, or placement for adoption of a child;
- You, your spouse, or your dependent having a change in employment status due to becoming employed or ceasing to be employed, a strike or lockout, beginning or ending an unpaid leave of absence, or a change in worksite;
- You, your spouse, or your dependent having a change in employment status that causes that person to gain or lose eligibility under the Cafeteria Plan or Benefit Plan(s) or any cafeteria plan or other employee benefit plans of the employer of your spouse or dependent;

Example: Sonja works for Employer A; her husband, Sven, works for Employer B. Sonja's employer maintains a cafeteria plan under which employees may elect no coverage, employee-only coverage or family coverage under a group health plan and may make a separate vision coverage election under the plan. Sonja elects family health coverage and no vision coverage. Sven's employer maintains a cafeteria plan with similar choices as Sonja's employer's plan. Sven elects no health coverage and employee-only vision coverage under B's plan. During the year, Sven terminates employment with B and loses vision coverage under B's plan. Sonja now wants to elect family vision coverage under A's plan. Sven's termination of employment is a change in status and the requested election change satisfies the consistency rules, so assuming Sonja makes the request in a timely manner, and assuming it is allowed by the underlying premium plan, Sonja may add family vision coverage (covering Sonja, Sven and their child) under A's cafeteria plan.

- Your dependent becomes eligible for coverage or is no longer eligible for coverage due to age, student status, or similar circumstances; or
- You, your spouse, or your dependent move or change residence.

A "dependent" for these purposes generally includes a child for whom the participant provides over half the support. The rules also apply to certain siblings, parents and other relatives. There are special

rules concerning dependents in divorce situations. Please see the Plan Administrator for more details about who qualifies as a dependent for Plan purposes.

3. What are the "consistency" rules that apply to a change in status?

The "consistency" rules vary depending upon the type of plan:

- *Consistency Rule for Group Insurance Premium Plan, Medical Reimbursement Plan and Individual Billed Medical Premium Plan:* Subject to the Special Consistency Rules described below in this Question and Answer II.H.3, any election change to these Plans must be **on account of** and must **correspond with** the change in status that affects eligibility under such Plan. A change in status that affects eligibility under the Plan includes a change in status that results in an increase or decrease in the number of your family members or dependents who may benefit from coverage under the Plan.

Example: Juan elected single coverage under his employer's health plan and elects pre-tax coverage for the premium under the Group Insurance Premium Plan. Juan also elected \$100 per month under the Medical Reimbursement Plan. Juan subsequently marries during the Plan Year. Juan's marriage is a change in status.

Juan could revoke his single-only coverage and elect family health coverage under his employer's health plan. In this case, Juan could increase his pre-tax election under the Group Insurance Premium Plan. Or, Juan could cancel coverage under his employer's health plan if his wife elects family coverage under her employer's health plan. In this case, Juan could cancel his pre-tax election under the Group Insurance Premium Plan. Either of these options would meet the consistency requirement.

Juan also could increase his election under the Medical Reimbursement Plan, to reflect the increase in the number of family members (that is, his new spouse), who are now eligible to benefit under the Medical Reimbursement Plan.

- *Consistency Rule for Dependent Care Assistance Plan:* Subject to the Special Consistency Rules described below in this Question and Answer 3, an election change is on account of and corresponds with a change in status if the change in status affects dependent care expenses.

Example: Tamra has one child. Tamra elects \$4,000 per year for dependent care assistance. During the Plan Year, Tamra's child reaches the age of 13 and is no longer an eligible dependent. Tamra can elect to cancel her dependent care assistance election.

- *Special Consistency Rule for divorce, annulment, or legal separation from your spouse:* Accident and health coverage can be canceled for the affected spouse, but no one else.

- *Special Consistency Rule for death of your spouse or dependent:* Accident and health coverage can be canceled for the deceased spouse or dependent, but no one else.
- *Special Consistency Rule for a dependent losing eligibility because of failure to satisfy the requirements:* Accident and health coverage can be canceled for the affected dependent, but no one else.
- *Special Consistency Rule for changes under the plan of a family member:* If you, your spouse or your dependent gain eligibility under the plan of an employer of a family member as a result of change in marital status or change in employment status, your election to cease or decrease coverage for such individual under the Cafeteria Plan or Benefit Plans corresponds with the change in status only if coverage becomes applicable or is increased under the family member plan.
- *Special Consistency Rule for disability and group term life coverage:* With respect to group term life and disability coverage, an election to increase (or decrease) coverage in response to a change in status is deemed to correspond with that change in status as required by the *Consistency Rule for Group Insurance Premium Plan, Dependent Care Assistance Plan and Individual Billed Medical Premium Plan.*
- *Special Consistency Rule for COBRA continuation coverage:* You may elect to increase payment under these Plans in order to pay for COBRA continuation coverage for yourself, spouse or dependent under an accident or health plan that the Employer sponsors.

4. What other rules apply to whether I can change my election due to a "change in status"?

- Any new election you make will be effective no earlier than the first pay period beginning after you have filed your new election with the Plan Administrator.
- You must make any new election **within 30 days** after the date of your change in status.

5. What other events affect my election mid-year?

There are other events that may result in a change in your election:

- You may cancel coverage for your child or dependent foster child if a judgment, decree or order (including a Qualified Medical Child Support Order) requires your spouse, former spouse, or other individual to provide coverage and if that coverage is, in fact, provided. The Plan Administrator may change your election without your consent if a judgment, decree or order requires coverage under your Plan.
- You may cancel coverage, if you, your spouse or dependent are enrolled in the Employer's health plan and become enrolled in Medicare or Medicaid (except for coverage solely for pediatric vaccines). Coverage may be added prospectively if you, your spouse, or your dependent lose eligibility for such coverage.

- If, due to loss of prior coverage or addition of a spouse or dependent to your family, you or your dependent(s) has(have) a right under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to a special enrollment in the Employer's group health plan, you can make a corresponding election under the Plan.
- If you take a FMLA or military leave during the Plan Year, refer to Section VII.B for information concerning the treatment of your elections.

6. May I change my election if the cost of my benefits changes?

Elections in the Cafeteria Plan or affected Benefit Plans (except Medical Reimbursement Plan) also may be affected by cost increases or decreases. A cost increase or decrease refers to a change in the amount of your elective contribution arising as a result of either an action taken by you, such as switching from full-time to part time status, or by an action taken by the Employer, such as reducing the amount of Employer contributions for a class of employees.

- If the cost of a Benefit Plan increases or decreases by an **insignificant** amount during the Plan Year, the amount of all affected participants' elections under the Cafeteria Plan and affected Benefit Plans **automatically** will increase or decrease on a prospective basis.
- If the cost of a Benefit Plan or an underlying accident or health plan option **significantly** increases or decreases during a Plan Year, you may make a corresponding prospective change in your election under the Plan and affected Benefit Plan. For example, if the cost of a particular underlying option under a Benefit Plan significantly decreases, you may choose to elect that option. In the case of a significant increase in the cost of an option in which you are enrolled, you may choose to increase your payment, or revoke your election and instead, either receive similar coverage if available under another Benefit Plan or drop coverage if no other option under the Benefit Plan or underlying accident or health plan provides similar coverage. A health flexible spending arrangement, such as the Medical Reimbursement Plan, is not similar coverage with respect to an accident or health plan that is not a health flexible spending arrangement. Coverage by another employer, such as a spouse's or dependent's employer, is treated as similar coverage.
- The Plan Administrator shall decide in its sole discretion, in accordance with prevailing IRS guidance, whether a cost increase or decrease is significant and what constitutes "similar coverage."
- Election changes due to cost change relating to **dependent care coverage** are only allowed if the cost change is imposed by a dependent care provider who is not related to you.

7. May I change my election if the coverage provided by my benefits changes?

Elections in the Cafeteria Plan or affected Benefit Plans (except Medical Reimbursement Plan) also may be affected by changes in coverage.

- If coverage under a qualified benefit plan is significantly curtailed without a loss of coverage (for example, there is a significant increase in the deductible), then you may revoke your

election for the affected coverage and make a new election on a prospective basis for coverage under another Plan option that provides similar coverage. Coverage under a Plan is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. In most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

- If the Plan coverage under a qualified benefit plan is significantly curtailed with a loss of coverage (for example, the HMO you have selected ceases to be available where you live), then you may either revoke your election for the affected coverage and elect coverage on a prospective basis under another Plan option that provides similar coverage, if any, or you may drop coverage, but only if there is no other option available under the Plan that provides similar coverage.

In accordance with prevailing IRS guidance, the Plan Administrator, in its sole discretion will decide whether a curtailment is significant and whether a loss of coverage has occurred. A loss of coverage may include:

- A complete loss of coverage such as an HMO ceasing to be available in the area in which the individual resides or an individual losing all coverage under the option by reason of an overall lifetime or annual limitation.
- A substantial decrease in the medical care providers available under the option you have selected, such as a major hospital ceasing to be a member of a preferred provider network.
- A reduction in the benefits for a specific type of medical condition or treatment for which you, your spouse or dependent are currently under treatment.
- If the Plan Administrator, in its sole discretion, determines that the coverage under an existing Benefit Plan option or other coverage option is significantly improved during the Plan Year, or if the Plan adds a new option, you may revoke your existing election and make a new election under the new or improved option on a prospective basis.
- You may elect to add group health coverage on a prospective basis if you, your spouse or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program ("SCHIP")).

8. May I change my election based on changes in coverage under another employer's plan?

You may make a prospective change that is on account of and corresponds with a change made under another employer's plan (including a plan of the Employer or a plan of your spouse's or your dependent's employer) if the other cafeteria plan or qualified benefits plan allows its participants to make a change that would be permitted under this Plan or if this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your spouse during his or her employer's open enrollment to drop coverage, and the plan year is different from this Plan, you may add coverage to replace the dropped coverage.

9. What change rules apply to the HSA Contribution Option?

You generally may change your contribution under the HSA Contribution Option at any time during the Plan Year, so long as the change is effective prospectively (that is, the change must only affect salary that you have not already earned). The Plan Administrator may impose limits on how often changes may be made but must permit prospective changes to be made at least on a monthly basis and must permit prospective revocation of future contributions if a participant becomes ineligible to make health savings account contributions.

10. What change rules apply to the Coverage Waiver Cash Option Plan?

You may not change an election under the Coverage Waiver Cash Option Plan during the Plan Year.

**III. GROUP INSURANCE PREMIUM PLAN AND/OR
INDIVIDUAL BILLED MEDICAL PREMIUM PLAN**

1. What benefits are offered under the Group Insurance Premium Plan?

The Group Insurance Premium Plan provides an opportunity to pay your share of the premiums for certain insurance benefits for yourself, your spouse and dependents, with pre-tax dollars. A description of the insurance benefits is set forth in insurance booklets, which are available to you without charge from the Plan Administrator.

2. What benefits are offered under the Individual Billed Medical Premium Plan?

The Individual Billed Medical Premium Plan allows you to pay for your own choice of medical insurance products on a pre-tax basis. Consult your individual policy for a description of benefits and contact your insurance company if you need assistance.

3. How does the Group Insurance Premium Plan and/or Individual Billed Medical Premium Plan work?

If you elect to receive benefits under the Group Insurance Premium Plan and/or Individual Billed Medical Premium Plan, your share of the cost of coverage will be subtracted from each of your paychecks. The amount of the reduction from your paychecks for coverage will equal the amount you are required to pay for the coverage you choose. This generally will remain fixed throughout the Plan Year, unless there is an automatic change in election or you are eligible and choose to make a mid-year change in election. (See Section II.H on mid-year changes). The amounts reduced from your paychecks will be paid on your behalf directly to your insurer(s) (or other allowable entities) that provides your coverage. Alternatively, in the case of the Individual Billed Medical Premium Plan, if the Plan Administrator permits reimbursements and you have properly substantiated your

expenses and completed the reimbursement forms, you will be reimbursed for the cost of the premium after you have paid the premium.

4. Are there tax consequences for disability coverage proceeds funded on a pre-tax basis through the Cafeteria Plan?

Generally, if short-term or long-term disability coverage is funded on a pre-tax basis through the Cafeteria Plan, the disability benefits you receive upon becoming disabled will be includible in your income. In addition, FICA taxes must be withheld and paid on all benefits during the first six months after the disability. You should consult your tax advisor for further details.

5. Are there tax consequences for group term life insurance proceeds funded on a pre-tax basis through the Cafeteria Plan?

Life insurance proceeds payable upon the death of the insured employee are not includible in income for Federal income tax purposes, regardless of whether the premiums are funded on a pre-tax or after-tax basis. See your Employer for information on the effect of paying the group term life insurance premium on a pre-tax basis and whether this increases your imputed income.

IV. MEDICAL REIMBURSEMENT PLAN

1. What benefits are offered under the Medical Reimbursement Plan?

If you have incurred certain medical, dental or vision expenses for yourself, your spouse or your dependents, you may be reimbursed for those expenses under the Medical Reimbursement Plan unless the Employer selected the Limited Expense option in Section II.A.4. (Note that individuals participating in or working for Employers offering Health Savings Accounts are limited in the types of expenses that can be covered under the Medical Reimbursement Plan. See Questions and Answers IV.12 and IV.13.) You will not be reimbursed for expenses reimbursed by insurance or some other source, except for expenses reimbursable under a Health Reimbursement Arrangement Plan, if offered by your Employer. (Your Medical Reimbursement Plan must be used first; any remaining eligible expenses may be submitted under a Health Reimbursement Arrangement Plan, if offered.) You do not have to itemize medical expenses on your tax return to be eligible for a reimbursement.

2. How and when do I get reimbursed?

You pay your expenses yourself. You must apply to the Plan Administrator (or a designated third party) for reimbursement of Qualifying Medical Care Expenses (described in Question and Answer IV.3) by submitting an application in writing to the Plan Administrator, on such medical reimbursement form as the Plan Administrator may prescribe, setting forth:

- The amount, date and nature of the expense;

- The name of the person, organization or entity to which the expense was paid;
- The name of the person for whom the expense was incurred and, if such person is not the participant requesting the benefit, the relationship of such person to the participant;
- The participant's written statement that the medical care expense has not been reimbursed or is not reimbursable under any other health plan coverage (except for a Health Reimbursement Arrangement Plan offered by the Employer, if any); and
- Such other information as the Plan Administrator may request.

Each application must be accompanied by a written statement from an independent third party stating that the medical expense has been incurred. An expense is incurred at the time the care or service giving rise to the expense is furnished. Such written statement may be a bill, invoice, receipt or other statement showing the amount of such expense, together with any additional documentation which the Plan Administrator may request.

The Plan Administrator will then process and pay reimbursement on qualifying claims. Reimbursements shall be issued on a regular basis subject to administrative rules on payments. Except for the final reimbursement claim for a Plan Year, no claim may be made unless and until the aggregate claim for reimbursement is at least \$10.

3. What if my Employer has a Grace Period?

Check Section II.A.4 to see if a Grace Period applies to your Plan. If a Grace Period applies, the following additional rules apply to Qualifying Medical Care Expenses that are incurred during a Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Qualifying Medical Care Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year.

Example: Assume that \$200 remains in Iris' Account at the end of the 2008 (calendar year) Plan Year and that she also has elected \$2,400 of Medical Reimbursement coverage for 2009. If Iris submits a \$500 Qualifying Medical Care Expense that was incurred on January 15, 2009, \$200 of her claim will be paid out of the unused amounts remaining in her Medical Reimbursement Account from the 2008 Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse her for Qualifying Medical Care Expenses incurred in the 2009 Plan Year.

- Claims will be processed in the order in which they are approved. Once paid, a claim will be not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For this reason, if you also have Medical Reimbursement coverage for the current year, you may want to wait to submit Qualifying Medical Care Expenses you

incur during the Grace Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

Example: Using the same facts as in the preceding Example, assume that a few days after being reimbursed for the \$500 Grace Period expense, Iris discovers \$200 of 2008 Plan Year Qualifying Medical Care Expenses that have not been submitted for reimbursement. She cannot be reimbursed for the newly-discovered expenses because no amounts remain to reimburse her for 2008 Plan Year expenses. The Plan will not reprocess the \$500 Grace Period expense so as to pay it entirely from her 2009 Plan Year Medical Reimbursement amounts.

Expenses incurred during a Grace Period must be submitted by the 90th day following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. See Question and Answer IV.6.

4. What kind of expenses can be reimbursed from the Plan?

Under the Medical Reimbursement Plan, only certain types of medical care expenses are eligible for reimbursement. These are called "**Qualifying Medical Care Expenses.**" "Medical Care" is defined under Internal Revenue Code Section 213(d) with some limitations. For example, long-term care services generally are not reimbursable. Generally, these medical expenses are those that are normally deductible on a Federal income tax return (without regard to the 7.5% adjusted gross income limitation) with some differences. If you are in a Plan selecting the Limited Expense option in Sec. II.A.4, you are limited to dental and vision expenses and no over-the-counter drugs. (Note that individuals participating in or individuals working for Employers also offering Health Savings Accounts are limited in the types of expenses that can be covered under the Medical Reimbursement Plan. See Questions and Answers IV.12 and IV.13.)

Qualifying Medical Care Expenses generally are limited by IRS rules to amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Amounts merely beneficial to the general health of an individual, such as an expenditure for a vacation, generally are not expenditures for qualifying medical care. Toiletries (e.g., toothpaste), cosmetics (e.g., face creams) and sundry items generally are not reimbursable.

You may be reimbursed for your own medical expenses. You also generally may be reimbursed for your spouse's or dependent's medical expenses. The Plan contains definitions of "spouse" and "dependent." Your "dependents" for purposes of the Plan generally are the persons who qualify as dependents on your Federal income tax return. Contact the Plan Administrator if you need additional information. Your payment for coverage under an Employer-sponsored health plan or individual health insurance policy, but not those charged by another employer, may be eligible for coverage through the Group Insurance Premium Plan or Individual Billed Medical Premium Plan as described in Questions and Answers III.1 and III.2, if applicable.

The following are examples of expenses that typically may be reimbursed; however, the facts of a situation generally may affect whether an expense is reimbursable. Please see your Plan Administrator to determine whether any specific medical expense is a Qualifying Medical Care Expense.

Examples of Qualifying Medical Care Expenses:

- Prescribed and over-the-counter medicine and drugs if used to alleviate or treat personal injuries or sickness.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- Medical examination, x-ray and laboratory service, and insulin treatment ordered by a physician.
- Nursing care. If someone does both nursing and housework, reimbursement only applies to the cost of the nursing care.
- Hospital care (including meals and lodging) and lab fees.
- Medical treatment at a center for drug addicts or alcoholics.
- Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs to get medical care.

Examples that are not Qualifying Medical Care Expenses:

- Premiums for health coverage for you, your spouse or dependent.
- Nursing care for a healthy baby.
- Dietary supplements (e.g., vitamins) if "merely beneficial" to general health.
- Illegal operations or drugs.
- Travel recommended by a physician for rest or change.
- Expenses eligible for reimbursement by insurance or other coverage.

5. What are the limits on the amount of expenses that can be reimbursed?

The maximum amount of medical expense reimbursement currently is listed in Section II.A.4 of this Summary. The amount of compensation reduction per pay period is your annual election divided by the number of pay periods remaining during the Plan Year after your entry in the Plan. If you become eligible to participate in the Plan mid-year, the full amount of the election is available to you. For example, if you become eligible mid-year and elect \$1,000 with 10 pay periods remaining in the year, \$100 will be subtracted from your pay each pay period. The Employer may modify the maximum amount, in which event you will be notified. The Employer may, at its option, charge you

a reasonable administrative fee to pay for the cost of administering the Reimbursement Plans. If an administrative fee is charged, you will be notified and the Employer will reduce your compensation by the amount of the administrative fee so that the fee will be paid with pre-tax dollars.

Expenses you have in a particular Plan Year (or Grace Period, if applicable) will be reimbursed only from amounts credited to you under the Plan for that year. The Federal tax laws impose limits on the amount of tax-free benefits provided to highly compensated or key employees as defined by Federal law. If the Plan Administrator determines that the Plan is not in compliance with such laws, the Plan Administrator may reduce the amount to be credited on your behalf to the Plan.

6. May I submit expenses I had before I became a participant or after the end of the Plan Year? What are Grace Periods?

Only expenses that are incurred on or after the date you became a participant and during a Plan Year (or Grace Period, if applicable) may be reimbursed from amounts credited to you for that Plan Year. For Qualifying Medical Care Expenses to be reimbursed to you from your Medical Reimbursement Account for the Plan Year Coverage Period, they ordinarily must have been incurred during that Plan Year Coverage Period. However, if a Grace Period applies (check Section II.A.4 to see if a Grace Period applies to your Plan), you may be able to be reimbursed from unused amounts remaining in your Medical Reimbursement Account at the end of a Plan Year for Qualifying Medical Care Expenses incurred during a "Grace Period" following the end of the Plan Year. Grace Periods begin on the first day of the Plan Year and end two months and 15 days later. Accordingly, for a 2008 calendar year plan, the Grace Period generally would be January 1, 2009 through March 15, 2009 and would apply to unused Medical Reimbursement amounts remaining at the end of the 2008 Plan Year.

An expense is incurred when the service is **performed** or the product is **purchased, not** when you receive the bill or make payment. Another way to look at it is that the expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred.

Example: If Banquo prepays on the first day of the month for medical care that will be given at the end of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

You will not be reimbursed for any expenses arising before the Medical Reimbursement Plan became effective, before your election became effective, for any expense incurred after the close of the Plan Year (except for certain expenses incurred during a Grace Period, as discussed below), or after a separation from service (except for COBRA continuation coverage, as described in Section VII.C.)

In order to take advantage of the Grace Period, you must be:

- A participant in the Plan with Medical Reimbursement coverage that is in effect on the last day of the Plan Year to which the Grace Period relates; or

- A qualified beneficiary who has COBRA continuation coverage under the Medical Reimbursement Plan on the last day of the Plan Year to which the Grace Period relates.

See Question and Answer IV.2 regarding certain rules that apply to claims for reimbursement for Qualifying Medical Care Expenses that are incurred during a Grace Period.

7. When must I file a claim for reimbursement?

You generally must file reimbursement requests for a Plan Year no later than 90 days after the end of that Plan Year. See Question and Answer IV.10 for reimbursement deadlines upon termination of participation. You will not be reimbursed if you file after the applicable deadline.

8. What if it is the beginning or middle of the Plan Year and I do not have enough credited to my Account to equal the amount of the medical expenses I have incurred?

You may file a reimbursement claim anyway. The Plan Administrator will reimburse your claim up to the total amount to be credited to your Account for the entire Plan Year (reduced by prior reimbursements for the same Plan Year). Expenses incurred during one year will not be reimbursed from amounts credited in later years. Therefore, to receive the most benefit from the Plan, you should try to set your compensation reduction level for each year high enough to reimburse you for expenses you reasonably expect to have during that year. At the same time, however, you should not set aside more than you need, as discussed in Question and Answer IV.9.

9. What if I have more credited to the Account than I need for medical coverage?

Because the Plans must conform with Federal tax law, you **cannot** carry over amounts from one Plan Year to the next. Any amounts remaining credited to your Account after payment of any expenses you have had on or before the last day of the Plan Year (or Grace Period, if applicable) **will be forfeited**. You **will not** receive a cash refund of unused amounts remaining credited to your Account. Therefore, you should be careful not to have significantly more credited to the Plan than you reasonably expect to use during the year.

10. What happens after I terminate employment?

Generally, no amounts will be credited to your Account after your employment with the Employer terminates or you otherwise cease to participate in the Plan. In addition, you generally will not be reimbursed for any expenses incurred after your participation stops.

In the event your participation ends, you must apply for reimbursement no later than 90 days after the close of the Plan Year. For additional information, including COBRA continuation coverage, please see Sections VII.A and VII.C.

11. What effect does reimbursement have on my medical expense deduction?

You may not claim a medical expense deduction on your Federal income tax return for expenses that were reimbursed from the Plan. (Remember, however, that you benefit from this Plan because reimbursements are not included in your gross income.)

12. What if I participate in a Health Savings Account?

Regardless of other provisions in this Summary, if you participate in a Health Savings Account for a Plan Year, your Medical Reimbursement Plan reimbursements are limited to dental and vision expenses for that Plan Year. Over-the-counter drugs also are not reimbursable. In addition note that a participant who has an election for the Medical Reimbursement Plan (other than the limited dental and vision) that is in effect on the last day of a Plan Year and is subject to a Grace Period may not be able to participate in a Health Savings Account for any of the first three months following the close of that Plan Year. See Question and Answer IV.13 for a special rule. The laws are evolving in this area. Check with your Health Savings Account plan administrator to determine the current law and restrictions that apply.

13. What if the Employer offers a Health Savings Account during a Grace Period?

If the Employer offers a Grace Period and also offers a Health Savings Account, then any participant who has an election for the Medical Reimbursement Plan that is in effect on the last day of a Plan Year is limited to dental and vision expense reimbursements (and no over-the-counter drugs) even if the participant does not participate in a Health Savings Account. This limitation applies for the Grace Period occurring in any Plan Year in which a Health Savings Account is offered.

V. DEPENDENT CARE ASSISTANCE PLAN

1. What benefits are offered under the Dependent Care Assistance Plan?

If you have incurred certain dependent care expenses, you may be reimbursed for those expenses to the extent amounts have been contributed to the Dependent Care Assistance Plan under your agreement to reduce your compensation.

IMPORTANT NOTE: You may save more money by paying your dependent care expenses yourself and claiming a tax credit rather than getting a reimbursement through the Plan. See Question and Answer V.12.

2. How do I get reimbursed?

You pay your dependent care expenses yourself. You must apply to the Plan Administrator (or a designated third party) for reimbursement of Qualifying Dependent Care Expenses (described in Question and Answer V.4) by submitting an application in writing to the Plan Administrator on such form as the Plan Administrator may prescribe, setting forth:

- The amount, date and nature of the expense;
- The name of the person, organization or entity to which the expense was paid;
- The name of the person for whom the expense was incurred and, if such person is not the participant requesting the benefit, the relationship of such person to the participant;
- The participant's written statement that the dependent care expense has not been reimbursed or is not reimbursable under any other dependent care assistance plan; and
- Such other information as the Plan Administrator may request.

Each application must be accompanied by a written statement from an independent third party stating that the dependent care expense has been incurred. An expense is incurred at the time the care or service giving rise to the expense is furnished. Such written statement may be a bill, invoice, receipt or other statement showing the amount of such expense, together with any additional documentation which the Plan Administrator may request.

The Plan Administrator then will process and pay your qualifying reimbursement claims to the extent you have sufficient amounts credited in your Dependent Care Assistance Account at the time of the reimbursement or payment. The amount of any Qualifying Dependent Care Expense not reimbursed because of an insufficient Account balance shall be carried forward within the same Plan Year and reimbursed only if and when the balance in the Account permits reimbursement.

3. Do I receive any reports?

On or before January 31 of each year, the Plan Administrator will furnish you with a statement showing the amount of dependent care assistance paid for your Account for the prior calendar year.

4. What expenses can be reimbursed for dependent care assistance?

"Qualifying Dependent Care Expenses" can be reimbursed. These expenses must have been:

- Incurred for the care of your "dependent" (described in Question and Answer V.5) or for related household services;
- Paid (or payable) to a Dependent Care Service Provider; and
- Incurred to allow you to be gainfully employed.

The expenses must be incurred for services rendered after the date of the election and during the Plan Year to which the election applies.

If the expenses are incurred for services outside the participant's household, the expenses must be incurred for the care of a dependent who is described in the first bullet point of Question and Answer V.5 or who regularly spends at least 8 hours per day in the participant's household.

You will not be reimbursed for expenses for overnight summer camp, that is, a camp where your dependent stays overnight. The cost of a day camp may be reimbursable. Furthermore, expenses for services provided by a day care center which provides care for more than 6 individuals may be reimbursed only if the center complies with all state and local rules.

You may use the Dependent Care Assistance Plan to reimburse yourself for the expense of services in your home if the services are for the care of your dependent so that you (and your spouse, if you are married) may work. For example, the cost of a housekeeper, cook, or practical nurse attending to your dependent in your home may be reimbursable. See the Plan Administrator for more information about whether your situation qualifies.

You will not be reimbursed for dependent care assistance for any services provided by your spouse, by a person with respect to whom you or your spouse could claim a deduction on your tax return, by any of your children who are under age 19, or by a parent of your under age 13 qualifying individual (described in the first bullet point of Question and Answer V.5).

5. Who are my "dependents" under the Dependent Care Assistance Plan?

Generally, for purposes of dependent care assistance reimbursement, your dependents are the following:

- Your child or descendant of your child, your sibling or step-sibling or their descendant, who is under age 13, who has not provided over one-half of his or her own support in the taxable year, and who has had the same principal place of abode as you for more than one-half of the year.
- Your spouse or tax dependent, if he or she is mentally or physically incapable of caring for himself or herself and if he or she has had the same principal place of abode as you for more than one-half of the year.

Code Sections 21 and 152 provide more details and restrictions, including income limitations.

6. Are there any limits on the amount of expenses that can be reimbursed?

Yes. Your reimbursement for dependent care assistance in your taxable year may not exceed \$5,000 (\$2,500 if you are married and file a separate Federal income tax return). In addition, the amount of expenses for which you are reimbursed in any year, even if less than the \$5,000/\$2,500 limit, may not exceed whichever of the following limits generally apply:

- If you are single, your net taxable pay (after all salary reductions for dependent care assistance) for the year the expenses are incurred.
- If you are married and your spouse is working, your net taxable pay (after all salary reductions) or the taxable pay of your spouse, whichever is less, for the year the expenses are incurred.
- If you are married and your spouse either is a full-time student or is physically or mentally incapable of caring for himself or herself, \$250 for each month of school or incapacity if you have only one dependent or \$500 for each month of school or incapacity if you have more than one dependent.
- The maximum reimbursement amount for the Dependent Care Assistance Plan as listed in Section II.A.3.

To satisfy these limits, you should make sure that your salary reduction for dependent care is not more than the amount of each of your paychecks after all amounts for dependent care have been subtracted. If you are married and your spouse's pay is less than your net paycheck, do not elect to contribute more than your spouse's pay (unless you qualify for the special \$250/\$500 exception). See Question and Answer VII.A.1 for additional limits.

The amount of compensation reduction per pay period is your annual election divided by the number of pay periods remaining during the Plan Year after your entry in the Plan. If you become eligible to participate in the Plan mid-year, the full amount of the election is available to you. For example, if you become eligible mid-year and elect \$1,000 with 10 pay periods remaining in the year, \$100 will be subtracted from your pay each pay period. The Employer may modify the maximum amount, in which event you will be notified. The Employer may, at its option, charge you a reasonable administrative fee to pay for the cost of administering the Reimbursement Plans. If an administrative fee is charged, you will be notified and the Employer will reduce your compensation by the amount of the administrative fee so that the fee will be paid with pre-tax dollars.

An additional limit may be imposed on the amount you have credited for dependent care assistance if you are a highly compensated or key employee, as defined under Federal tax laws. Federal tax laws impose limits on the amount of tax-free dependent care benefits provided to highly compensated employees. If the Plan Administrator determines a reduction is necessary to comply with such laws, you will be contacted.

7. May I submit expenses incurred before I become a participant or after the end of a Plan Year?

No. Only expenses you have on or after the date you become a participant and during a Plan Year may be reimbursed in that Plan Year. There is no Grace Period applicable for dependent care assistance expenses.

You have an expense when the service is performed, **not** when you receive the bill or make payment. **Expenses you have within a particular Plan Year will be reimbursed only from the amounts credited to your Dependent Care Assistance Account for that year.**

8. When must I file a claim for reimbursement?

You must file reimbursement requests for a given Plan Year no later than 90 days after the end of the Plan Year during which you have had the dependent care expenses. (See also Question and Answer V.11.)

9. What if it is the beginning or middle of the Plan Year and I do not have enough credited to my Account to equal the amount of the dependent care expenses I have incurred?

You may file a reimbursement claim anyway. The Plan Administrator will issue a partial reimbursement if you have an amount credited to your Account at that time. No reimbursement at any time shall exceed the balance in your Dependent Care Assistance Account (note that this is different than the rule for the Medical Reimbursement Plan). Additional payments will be made when the balance in your Account permits such reimbursement. However, expenses you have during one year will not be reimbursed from amounts credited in later years. Therefore, to receive the most benefit from the Plan, you should try to set the amount by which you reduce your compensation for each Plan Year high enough to reimburse you for dependent care expenses you reasonably expect to have that year. At the same time, however, you should not set aside more than you need, as discussed in Question and Answer V.10.

10. What if I have more credited to the Plan than I need for dependent care expenses?

Because the Plans must conform with Federal tax law, you **cannot** carry over amounts from one Plan Year to the next. Any amounts remaining credited to your Dependent Care Assistance Account after payment of any expenses you have had on or before the last day of the Plan Year **will be forfeited**. You **will not** receive a cash refund of unused amounts remaining credited to your Account. Therefore, you should be careful not to have significantly more credited to the Plan than you reasonably expect to use during the year.

11. What happens after I terminate employment?

No amounts will be credited to your Dependent Care Assistance Account after your employment with the Employer terminates or you otherwise cease to participate in the Plan. In order to receive reimbursement after your participation ends, you must apply for reimbursement within 90 days after the end of the Plan Year. Any unused amounts remaining in your Account will be forfeited. See Section VII.A for additional information.

12. What effect does reimbursement under the Plan have on my Federal tax credit for dependent care expenses?

Apart from this Plan, a credit against your Federal income tax liability may be allowed for a percentage of your eligible dependent care expenses. The amount of eligible dependent care expenses that you may take into account when calculating the credit is limited to \$3,000 for one dependent, or \$6,000 for two or more dependents. In certain cases, it may be better for you to claim a tax credit for your dependent care expenses rather than paying for those expenses through the Dependent Care Assistance Plan. It is up to you to decide what to do. As a rule of thumb, the lower your income, the more valuable the tax credit may be. Some of the features of the credit are discussed in this Question and Answer V.12. This is not legal or tax advice; you should consult your tax advisor for details.

Calculation of the amount of credit for which you may be eligible depends upon a number of factors, including your income. Further, the amount of dependent care expenses that may be taken into account when calculating the tax credit is reduced, dollar for dollar, by the amount of expenses that are reimbursed from the Plan. For example, suppose you have one dependent. You have \$8,000 of dependent care expenses in one year, and you are reimbursed under the Plan for \$4,000 of those expenses. The amount of expenses otherwise eligible for the tax credit (\$3,000 if you have one dependent; \$6,000 if there is more than one dependent) is reduced by the amount of expenses reimbursed from the Plan (\$4,000). Therefore, in this example, you could not claim a dependent care tax credit for one dependent for the year. However, if you have one dependent and were reimbursed from the Plan for only \$1,000 of expenses, then \$2,000 of expenses (\$3,000 - \$1,000) can be taken into account in determining the tax credit.

There may be other tax credits that may be affected by your participation in the Dependent Care Assistance Plan or by your claiming the dependent care expense tax credit. See your personal advisor. Remember that the rules may change from time to time, and that the Plan, Employer, and Plan Administrator are not providing legal or tax advice.

VI. HSA CONTRIBUTION OPTION AND COVERAGE WAIVER CASH OPTION PLAN

1. What is an HSA?

A health savings account, or "HSA" is a special type of individual account that an individual must establish with a qualified HSA trustee or custodian, like a bank. An HSA allows eligible individuals to pay for certain medical expenses on a tax-free basis. HSA contributions can be made by an eligible individual's employer, the individual, or both.

If your Employer offers the HSA Contribution Option under the Cafeteria Plan, you will be provided a separate Summary of Health Savings Account Features, which will be a part of this Summary.

2. How does the Cash Option Plan work?

If you are covered under a health insurance plan not sponsored by the Employer, you may waive coverage under the Employer's health insurance plan and receive additional cash compensation. (This does not apply to the dental plan.) The Plan Administrator will provide you with information about the amount of cash compensation available.

To elect the cash option, you must complete a waiver of benefits and maintenance of eligibility rights and/or such other forms as the Plan Administrator may require. You also must provide proof of coverage under the other plan in such form as the Plan Administrator may require.

3. What if there is a change in the cost of my other health coverage?

Generally, you may not revoke an election under the Coverage Waiver Cash Option Plan during the Plan Year. For changes that become effective the first day of the Plan Year, you may revoke your election to participate in the Cash Option Plan for the new Plan Year by filing the appropriate form with the Plan Administrator before the deadline.

VII. OTHER INFORMATION ABOUT THE PLANS

A. ENDING PARTICIPATION

1. When will my participation in the Plans end?

Participation will end if you no longer meet the eligibility requirements. Participation in the Cafeteria Plan and Benefit Plans also will end if the Cafeteria Plan is terminated. Participation in a Benefit Plan also will end if the Benefit Plan is terminated. Your participation in the Dependent Care Assistance Plan also will end if your compensation becomes less than twice the amount of the specified compensation reduction. To the extent allowed by law, your participation also will end if you do not make contributions required under the Plans.

If you cease to be a participant in the Group Insurance Premium Plan or Individual Billed Medical Premium Plan for any reason, the payment of premiums under the Cafeteria Plan and related Group Insurance Premium Plan or Individual Billed Medical Premium Plan will terminate.

2. What happens when my participation in the Plans ends?

Once your participation in a Plan or Plans stops, you generally will not receive any further credits to your Accounts in the affected Plan(s) and the reduction of your compensation will end. Except as provided below, if your participation in any of the Plans stops mid-year, you will not be able to make new elections if you meet the participation requirements to re-enter the Plan until the next Plan Year, subject to the eligibility and participation rules for FMLA or USERRA leaves.

If you cease to be eligible due to termination of your employment and you are rehired after more than 30 days, but in the same Plan Year, you may participate to the extent you are eligible and make new elections. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year unless you are not eligible for the underlying health coverage under the Group Insurance Premium Plan or Individual Billed Medical Premium Plan.

The following also will apply:

- With respect to the Medical Reimbursement Plan, you only will be reimbursed for expenses incurred **prior** to your termination **unless** you qualify for and elect to continue to make payments to the Plan for the remainder of the Plan Year under COBRA continuation coverage, as explained in Section VII.C. This may allow you to receive elected reimbursement benefits beyond your termination date and not forfeit your unused Account balance as of your termination date.

- With respect to the Dependent Care Assistance Plan, you can be reimbursed only for expenses incurred **prior** to your termination up to the amount credited to your Dependent Care Assistance Account at the time of your termination.

You also may be entitled to continue to participate in the Group Insurance Premium Plan (with respect to underlying health benefits) and Individual Billed Medical Premium Plan pursuant to any rights you have under COBRA, as explained in Section VII.C.

B. FAMILY, MEDICAL, OR UNIFORMED SERVICES LEAVE; COURT ORDERS

1. What happens to my benefits if I go on family and medical leave?

You may (but are not required to) revoke your elections with regard to the Group Insurance Premium Plan (with respect to a group health plan) and Medical Reimbursement Plan if you go on a family or medical leave that is subject to the Federal Family and Medical Leave Act of 1993 ("FMLA") or, in some cases, similar state laws, if applicable. (You also may be entitled to revoke your election with respect to the Individual Billed Medical Premium Plan if it meets the FMLA's definition of group health plan. See the Plan Administrator to find out if your Individual Billed Medical Premium Plan is subject to the FMLA.) In addition, if you are on FMLA leave, you may revoke elections as to non-health benefits (for example, Dependent Care Assistance elections) to the same extent employees taking non-FMLA leaves are permitted to revoke elections of non-health benefits (for example, if you have a change in status). If your coverage under the Medical Reimbursement Plan ends while you are on FMLA leave, you are not entitled to receive reimbursements for claims incurred after the coverage terminated.

If you continue to participate in any of the Plans while on an unpaid FMLA leave, you must pay the amounts which normally would be paid through salary reduction. You may do this in one of three ways, as determined by the Plan Administrator:

- **Prepayment:** You may prepay any amounts which otherwise would be deducted from your compensation for the period of the FMLA leave. This amount will be taken on a pre-tax basis, to the extent possible, from your compensation prior to the leave.
- **Pay-As-You-Go:** You may continue to pay your contributions while on an FMLA leave on the same schedule that generally would apply if you were not on leave. Your contributions will be due on or before the date such amounts normally would have been deducted from your paycheck. Under this method, your payments typically are made on an after-tax, not pre-tax, basis.
- **Catch-Up:** You and the Employer may agree in advance that coverage will continue during the period of FMLA leave, and that you will not pay premiums until you return from the leave.

If you receive compensation while on an FMLA leave (that is, you are on a paid FMLA leave), then amounts will be deducted from your paychecks in the same manner as when you are actively at work to the extent you continue to participate in the Plans.

The Employer may from time to time limit the payment options that are available to you. (However, the Prepayment and Catch-Up options may not be offered without also offering the Pay-As-You-Go option.) Please see the Plan Administrator before your leave to see which options are available at that time.

When you return to work from an FMLA leave, you have a right to be reinstated in the Group Insurance Premium Plan (and Individual Billed Medical Premium Plan, if applicable). However, you do not have this right to immediate reinstatement in the Dependent Care Assistance Plan or HSA Contribution Option under the FMLA, and you will be subject to your Employer's rules that govern rights on leaves of absence.

If your coverage under the Medical Reimbursement Plan ended while you were on FMLA leave, you will be required to resume participation in that Plan upon return to work for the remainder of the Plan Year if employees who return from other types of leave are also required to resume participation upon return from leave. When you resume making payroll reduction contributions to the Medical Reimbursement Plan, you may either resume coverage at the level in effect before the FMLA leave, and make up the unpaid premium payments, or resume coverage at a level that is reduced and resume premium payments at the level in effect before the FMLA leave. If you choose to resume coverage at the level that is reduced, the coverage is prorated for the period during the FMLA for which no premiums were paid. In both cases, the coverage level is reduced by prior reimbursements.

Example 1: Ron elects \$1,200 worth of coverage under the Medical Reimbursement Plan and pays \$100 per month through pre-tax salary reduction. Ron incurs no medical expenses prior to April 1. On April 1, Ron takes FMLA leave after making three months of contributions totaling \$300. Ron revokes coverage under the Medical Reimbursement Plan during the FMLA leave. As a result, he makes no premium payments for the months of April, May, and June, and is not entitled to submit claims or receive reimbursements for expenses incurred during this period.

When Ron returns from leave, he may either resume coverage at the level in effect before the FMLA leave (that is, \$1,200), making up the unpaid premium payments (\$300), or resume Medical Reimbursement Plan coverage at a level that is reduced on a prorata basis for the period during the FMLA leave for which no premiums were paid (that is, reduced for 3 months, or 1/4 of the Plan Year), less prior reimbursements (that is, -0-) with premium payments due in the same monthly amount payable before the leave (that is, \$100 per month). If Ron chooses to resume coverage at the level in effect before the FMLA leave, his coverage for the remainder of the Plan Year would equal \$1,200 and his monthly premium would be increased to \$150 per month for the remainder of the Plan Year, to make up the \$300 in premiums missed. If Ron chooses prorated coverage, his coverage for the remainder

of the Plan Year would equal \$900, and he would resume making premium payments of \$100 per month for the remainder of the Plan Year.

Example 2: Assume the same facts as Example 1, except that Ron incurred medical expenses totaling \$200 in February and obtained reimbursement of these expenses. When he returns from FMLA leave, if Ron chooses to resume coverage at the level in effect before the leave, his coverage for the remainder of the year would equal \$1,000 (\$1,200 reduced by \$200) and the monthly payments for the remainder of the year would still equal \$150. If instead Ron chooses prorated coverage, his coverage for the remainder of the Plan Year would equal \$700 (\$1,200 prorated for 3 months, and then reduced by \$200) and the monthly payments for the remainder of the year would still equal \$100.

Example 3: Again assume the same facts as Example 1, except that, prior to taking FMLA leave, Ron elects to continue Medical Reimbursement Coverage during the FMLA leave. The plan permits Ron to use the Catch-Up payment option to repay the \$300 in missed payments on a ratable basis over the remaining 6-month period of coverage (that is, \$50 per month). Ron's monthly premium payments for the remainder of the Plan Year will be \$150 (\$100 + \$50).

The Plan's FMLA procedures will comply with any additional requirements mandated by applicable law. Contact the Employer to determine whether FMLA applies.

2. What happens to my benefits if I go on military leave?

If you leave work for military duty in the uniformed services that is covered under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), then you have certain rights under the Plans.

In general, you may make the same type of elections as described in Question and Answer VII.B.1 for FMLA leave. If you are on a uniformed services leave, you and your spouse and dependents have a right to elect coverage of the lesser of: 24 months of continuation coverage under the Medical Reimbursement Plan, Group Insurance Premium Plan (with respect to a health plan), and Individual Billed Medical Premium Plan, as applicable, of group health benefits to the extent required by law, beginning on the date the uniformed services leave begins; or the period ending on the date you fail to apply for or return to active employment with the Employer.

Generally, a person who elects to continue coverage under USERRA leave may be required to pay up to 102 percent of the full premium under the Plan. However, if you are on leave for less than 31 days, such person will pay only the employee share, if any, for such coverage.

While on uniformed services leave, you generally are entitled to non-health benefits on the same terms and on the same basis as those benefits are offered to other employees on a leave of absence.

The Plan will comply with any requirements under USERRA or other Federal laws relating to military service to the extent required by those laws. If you go on military duty, please see the Plan Administrator for more information.

3. How can a Qualified Medical Child Support Order affect my benefits?

You may be required to modify your elections under the Cafeteria Plan health benefits subject to these orders, including to continue participation, in order to provide coverage for your child pursuant to an order issued by a court, or a notice issued by certain state agencies, that qualifies as a Qualified Medical Child Support Order ("QMSCO"). You will be notified if the Plan Administrator receives such an order affecting your Cafeteria Plan group health benefit participation. The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. Participants may obtain, without charge, a copy of such procedures from the Plan Administrator.

C. CONTINUATION OF COVERAGE AFTER CERTAIN EVENTS

1. Introduction to COBRA Continuation Coverage

The following information about your right to continue your health care coverage (as applicable) in the Plans is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage otherwise would end. This Section VII.C generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you otherwise would lose your group health coverage under the Plan. It also can become available to your spouse and dependent children, if they are covered under the Plan, when they otherwise would lose their group health coverage under the Plan. The Plan Administrator will determine the extent to which COBRA may apply. Please contact the Plan Administrator for more details.

2. What benefits under the Plans and what Employers are subject to COBRA continuation coverage?

COBRA may apply to the Group Insurance Premium Plan (with respect to underlying health benefits). You also may be able to elect to continue to make contributions to and receive reimbursements under the Medical Reimbursement Plan.

COBRA does not apply to the Dependent Care Assistance Plan or HSA Contribution Option. Additionally, COBRA does not cover group term life insurance plans, or short- or long-term disability plans, except to the extent that such plans may provide benefits for medical care subject to COBRA, if any. The Plan's continuation coverage procedures will comply with any additional requirements that may be mandated by applicable law.

COBRA does not apply to Employers with less than 20 employees as determined under the regulations. Contact your Employer if you have a question as to the application of this exception. Unless otherwise provided in an Addendum to this Summary, this Summary is drafted under the assumption that the Individual Billed Medical Premium Plan benefits (with respect to the underlying policy), if applicable, are not subject to COBRA. Contact your Employer if you have questions about or whether COBRA applies. The Plan provides no greater COBRA rights than what COBRA requires nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements. Participants, spouses, or dependents may contact the Employer to see if COBRA applies to them.

3. What is "COBRA continuation coverage" and what are the special COBRA rules for the Medical Reimbursement Plan?

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "**qualifying event.**" Specific qualifying events are listed in Question and Answer VII.C.6.

After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA continuation coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary" (see Question and Answer VII.C.4). Unless otherwise elected, all qualified beneficiaries who were covered under the Medical Reimbursement Plan will be covered together for the Medical Reimbursement Plan COBRA continuation coverage.

COBRA coverage under Medical Reimbursement Plan Accounts subject to the HIPAA exception (see Question and Answer VII.E.2) which provide for an annual COBRA premium greater than or equal to the annual coverage amount may be subject to limited COBRA compliance. In such case COBRA continuation coverage will be offered only to qualified beneficiaries losing coverage who have "underspent" accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Medical Reimbursement Plan COBRA continuation coverage that will be charged for the remainder of the Plan Year.

Limited COBRA continuation coverage will consist of the Medical Reimbursement Plan coverage in force at the time of the qualifying event (that is, the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The rule regarding forfeiture of unused accounts (see Section II.G) will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year (or Grace Period, if applicable), and COBRA continuation coverage will terminate at the end of the Plan Year in which your qualifying event occurred. Certain events, such as your failure

to pay the amounts you owe or the Employer's decision to terminate the Plan, may shorten the period of coverage. See the Plan Administrator if you have questions as to whether a Medical Reimbursement Plan benefit is subject to full or limited COBRA compliance or for more information.

4. Who is a "qualified beneficiary" eligible for continuation coverage under COBRA?

Continuation coverage under COBRA only is available for "**qualified beneficiaries.**" A covered employee, spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event (defined in Question and Answer VII.C.6). Special rules may apply to the Medical Reimbursement Plan. See Question and Answer VII.C.3.

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. The child's COBRA continuation coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA continuation coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

5. How does COBRA continuation coverage compare to my current coverage and who pays for it?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under that benefit under the Plan who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan with respect to the elected benefit as other participants or beneficiaries covered under that benefit under the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. If coverage is modified for similarly-situated participants, then COBRA continuation coverage will be modified in the same way.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

6. What are a qualifying events?

If you are an **employee**, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse** of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Under COBRA, Medicare "entitlement" means that a person who is eligible for Medicare actually has become enrolled in Medicare.

If you are the **dependent child** of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than his or her gross misconduct;
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- Your parents become divorced or legally separated; or
- You stop being eligible for coverage under the Plan as a "dependent child."

However, as discussed in the Section VII.C.3, COBRA continuation coverage under the Medical Reimbursement Plan may be limited.

Sometimes, filing a proceeding in **bankruptcy** under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired

employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan or coverage is substantially reduced within one year before or after the Employer's bankruptcy.

7. When does FMLA leave or military leave result in a COBRA election?

If an employee takes FMLA leave and does not return to work at the end of the FMLA leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA continuation coverage at the end of the FMLA leave:

- If they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
- If they will lose Plan coverage within 18 months of and due to the employee's failure to return to work. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

COBRA continuation coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. See Questions and Answers VII.B.1 and VII.C.23.

See Section VII.B.2 or the Plan Administrator for information about military leave.

8. How does trade adjustment assistance affect COBRA elections?

Special COBRA election rights apply to individuals eligible for certain payments (including eligible alternative recipients) under the Trade Act of 1974 who lost group health plan coverage due to a job loss. These individuals are entitled to a second opportunity to elect COBRA continuation coverage (if they did not already elect COBRA continuation coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the individual becomes eligible for the trade adjustment assistance, but only if the election is made within the 6 months immediately after the individual's group health plan coverage ended. If you qualify or may qualify, contact the Employer using the Plan contact information provided in Question and Answer VII.C.29. **Contact the Employer promptly after qualifying or you will lose the right to elect COBRA during a special second election period.**

9. When is COBRA continuation coverage available and who must give notice of qualifying events?

The Plan will offer COBRA continuation coverage to qualified beneficiaries **only after proper notice has been provided** to the Plan Administrator.

- **Employer Notice to the Plan Administrator:** When the qualifying event is the end of employment (other than for gross misconduct), reduction of hours of employment, or death of the employee; the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or the commencement of a proceeding in bankruptcy with respect to the Employer, the Employer must notify the Plan Administrator of the qualifying event. The qualified beneficiaries will be notified of the right to elect COBRA continuation coverage. You need not notify the Employer of any of these qualifying events.
 - **You Must Give Notice of Some Qualifying Events:** When the qualifying event is **divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child**, a COBRA election will be available to you only if you (the employee or the qualified beneficiary) notify the Employer in writing within 60 days after the later of:
 - The date of the qualifying event; and
 - The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.
- Note:** You may have additional notification obligations, e.g., if certain qualifying events occur after you have elected COBRA continuation coverage. See the discussion at Questions and Answers VII.C.24 and 25.

10. What steps must I follow in giving notice of a qualifying event?

In providing notice of a qualifying event, you must use the Plan's form "**Notice of Qualifying Event**," and you must follow the procedures specified in the Question and Answer VII.C.29. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **you will lose your right to elect COBRA**. You may obtain a copy of the form from the Employer.

11. How is COBRA continuation coverage provided and do qualified beneficiaries have an independent right to elect coverage?

Once the Plan Administrator receives notice that a qualifying event has occurred, any applicable COBRA continuation coverage will be offered to each of the qualified beneficiaries. The length of the coverage varies depending upon the individual's situation. Important information on the length of the coverage is provided in the Questions and Answers that follow in this Section VII.C.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Any qualified beneficiary for whom **COBRA is not elected within the 60-day election period** specified in the Plan's COBRA election notice **will lose his or her right to elect COBRA continuation coverage.**

12. If I am enrolled in one or more group health benefits, what coverages are available?

If you or your eligible family members qualify for such continuation coverage, the benefits will be treated as separate coverages for purposes of COBRA. Accordingly, if employer offers multiple benefits, and at the time of the qualifying event, an active employee had elected both coverage under two health benefits, under COBRA, the employee may be able to elect to continue coverage for either coverage or both.

13. What if I have other group health coverage or am entitled to Medicare?

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. Under COBRA, Medicare "entitlement" means that a person who is eligible for Medicare actually has become enrolled in Medicare. However, as discussed in more detail in Question and Answer VII.C.25, a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

14. What notification obligations arise if a qualified beneficiary becomes entitled to Medicare?

When you complete the **Election Form**, you must notify the Employer if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the **Election Form**, immediately notify the Employer of the date of your Medicare entitlement in writing at the address and in the manner specified in Question and Answer VII.C.17 for submission of the **Election Form**.

15. What steps are required to elect COBRA continuation coverage?

To elect COBRA, you or the qualified beneficiary must complete the **Election Form** that is part of the Plan's COBRA election notice and submit it to the Employer. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You or other qualified beneficiaries also may obtain a copy of the **Election Form** from the Employer.

16. How much time is allowed to make the COBRA continuation coverage election?

Under Federal law, a qualifying beneficiary must have **60 days** after the date of the COBRA election notice provided at the time of the qualifying event to decide whether to elect COBRA under the Plan.

17. How is the COBRA continuation coverage Election Form completed and submitted?

The qualified beneficiary must mail or hand deliver the completed **Election Form** to: Human Resources Department, Employer (see Section II.A for Employer address).

The Election Form must be completed in writing. The following are **not** acceptable as COBRA elections and will **not** preserve COBRA rights:

- Oral communications regarding COBRA continuation coverage, including in-person or telephone statements about an individual's COBRA continuation coverage; and
- Electronic communications, including e-mail and fax.

If mailed, your election must be postmarked or, if hand-delivered, your election must be received by the individual at the address specified above, no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event or, if later, no later than 60 days after the date that the benefit coverage terminates. **If you do not submit a completed election form by this due date, you will lose your right to elect COBRA.**

18. What if I file an Election Form rejecting COBRA, but later change my mind?

If you reject COBRA before the due date, you may change your mind as long as you furnish a revised completed **Election Form** before the due date. However, coverage will not be provided retroactively. In such a case, coverage will be provided only from the date the waiver is revoked.

19. Do I have to send payments with my COBRA continuation coverage Election Form?

No. You do not have to send any payment with your **Election Form** when you elect COBRA. Important additional information about payment for COBRA continuation coverage is included in other Questions and Answers in this Section VII.C.

20. If I decide not to elect COBRA, could this affect my future rights?

Yes. In considering whether to elect COBRA, you should take into account that a failure to elect COBRA may affect your future rights under Federal law. Some special considerations include the following:

- You can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap.
- You can lose the Federal guaranteed conversion rights to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

You should take into account that you may have special enrollment rights under Federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed in Question and Answer VII.C.6. You also may have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

As a general matter, these Federal rights may apply only to certain medical benefits. See Section VII.E of the Summary Plan Description for more information.

21. What is the cost of COBRA continuation coverage?

Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage as determined by the Plan Administrator, in accordance with applicable law. The Employer may charge an administrative fee in addition to the amount of the required contribution. However, the amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost of the group health benefit (including both Employer and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving such COBRA continuation coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA continuation coverage and will most likely increase over time. You will be notified of COBRA premium changes.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("eligible individuals"). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act also is available at www.doleta.gov/tradeact/2002act_index.asp.

22. How is payment made for COBRA continuation coverage?

(a) General. All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA continuation coverage must be mailed or hand-delivered to:

Human Resources Department, Employer (see Section II.A for Employer address).

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

(b) First Payment. If you elect COBRA, you do not have to send any payment with the **Election Form**. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (The date of your election, if mailed, is the date your **Election Form** is postmarked; or if hand-delivered, the date your **Election Form** is received by the individual at the address specified for delivery of the **Election Form**.) See Question and Answer VII.C.17.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan otherwise would have terminated up through the end of the month before the month in which you make your first payment.

Example: Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided in Question and Answer VII.C.28 to confirm the correct amount of your first payment. Claims for reimbursement under indemnity-type benefits will not be processed or paid prior to the time you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

(c) Monthly Payments. After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event.

Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA continuation coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA continuation coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA continuation coverage - it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a special grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the special grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the special grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the special grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan.

23. How long does COBRA continuation coverage last?

COBRA continuation coverage is a temporary continuation of coverage. The COBRA continuation coverage periods described below are maximum coverage periods. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons, which are described in Question and Answer VII.C.25. If you are eligible for limited COBRA continuation coverage under the Medical Reimbursement Plan, coverage ends on the last day of the Plan Year in which the qualifying event occurred. See Question and Answer VII.C.3.

- **36 months:** When Plan coverage is lost due to a qualifying event that is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage can last for **up to a total of 36 months**.
- **18 months extended 36 months:** When Plan coverage is lost due to a qualifying event that is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits **less than 18 months before the qualifying event**, COBRA continuation coverage **for qualified beneficiaries (other than the employee)** who lose coverage as a result of the qualifying event can last until **up to 36 months after the date of Medicare entitlement**.

Example: An Employer offers medical benefits. If a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage under the Plan's medical benefits for his spouse and children who lost coverage as a result of his termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA continuation coverage period is available

only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

- **18 months:** When Plan coverage is lost due to the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, COBRA continuation coverage generally can last for only **up to a total of 18 months**. See Question and Answer VII.C.24 for information on extensions of the 18-month period.

24. When can there be an extension of the maximum coverage period (generally not applicable to Medical Reimbursement Plan)?

(a) General. If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is **disabled** or a **second qualifying event occurs**. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA continuation coverage. **Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA continuation coverage.** A period of limited COBRA continuation coverage under the Medical Reimbursement Plan cannot be extended under any circumstance. (These extension opportunities do not apply to a period of COBRA continuation coverage resulting from other qualifying events, such as, but not limited to, a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

(b) Disability Extension. If a qualified beneficiary is **determined by the Social Security Administration to be disabled** and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA continuation coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described in Question and Answer VII.C.23). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage for the benefit under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You also must provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

In providing this notice, you must use the Plan's form "**Notice of Disability**" and you must follow the procedures specified in Question and Answer VII.C.29. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **then there will be no disability extension of COBRA continuation coverage**. You may obtain a copy of the form from the Employer.

(c) Second Qualifying Event Extension. An extension of coverage will be available to spouses and dependent children who are receiving COBRA continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months.

Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, but do not include a bankruptcy qualifying event. The eligible events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the Employer in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; and
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the Plan's form "**Notice of Second Qualifying Event**" and you must follow the procedures specified in Question and Answer VII.C.29. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **then there will be no extension of COBRA continuation coverage due to a second qualifying event**. You may obtain a copy of the form from the Employer.

25. When can COBRA continuation coverage terminate before the end of the maximum coverage period?

COBRA continuation coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;

- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). If the other plan has applicable exclusions, then your COBRA continuation coverage will terminate after the exclusion no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. This will apply only to the person who becomes entitled to Medicare;
- The Employer ceases to provide any group health coverage for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see Question and Answer VII.C.24.

COBRA continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

You must notify the Employer in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form "**Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability,**" and you must follow the procedures specified in Question and Answer VII.C.29. You may obtain a copy of the form from the Employer.

COBRA continuation coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the Employer of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form "**Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability,**" and you must follow the procedures specified in Question and Answer VII.C.29. You may obtain a copy of the form from the Employer.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA continuation coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Employer (or its designee) will require repayment to the Plan of all

benefits paid after the termination date, regardless of whether or when you provide notice to the Employer that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see Question and Answer VII.C.24.

26. What if I have other questions?

Questions concerning your Plan or your COBRA rights should be addressed to the contact identified in Question and Answer VII.C.28. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

27. Am I required to keep the Plan informed of address changes?

Yes. In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You also should keep a copy, for your records, of any notices you send to the Employer.

28. What is the Plan contact information?

You may obtain information about the Plan and COBRA continuation coverage on request from: Human Resources Department, Employer (see Section II.A for Employer address).

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you are not sure whether this is the Plan's most recent summary plan description, you may request the most recent one from the Employer).

29. What are the Notice Procedures for the Plan?

The following are the **Notice Procedures** that apply to the Plan.

COBRA CONTINUATION COVERAGE NOTICE PROCEDURES

(a) Notice Procedures for Notice of Qualifying Event

(1) Deadline. The deadline for providing this notice is 60 days after the later of:

- The qualifying event (that is, a divorce or legal separation or a child's loss of dependent status); and
- The date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

- (2) **Delivery.** You must mail or hand deliver this notice to:
Human Resources Department, Employer (see Section II.A for Employer address).

Your notice must be in writing (using the Plan's form described in Question and Answer VII.C.29(a)(3)) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described in Question and Answer VII.C.29(a)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer VII.C.29(a)(1).

- (3) **Required Form and Information.** You must use the Plan's form "**Notice of Qualifying Event**" to notify the Employer of a qualifying event (that is, a divorce or legal separation or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer.)

Your notice must contain the following information:

- The name of the Plan (Cafeteria Plan, Group Insurance Premium Plan (with respect to underlying health benefits) and/or Medical Reimbursement Plan of (specify Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- The qualifying event (divorce, legal separation, or child's loss of dependent status);
- The date that the divorce, legal separation, or child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these **Notice Procedures for Notice of Qualifying Event** and must in addition provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these **Notice Procedures for Notice of Qualifying Event**, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed or hand-delivered to the individual and address specified in Question and Answer VII.C.29(a)(2);
- The notice is provided by the deadline described in Question and Answer VII.C.29(a)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan;
- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Qualifying Event**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the **Notice of Qualifying Event** described in Question and Answer VII.C.29(a)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the Employer requests it, provide documentation of the date of the qualifying event that is satisfactory to the Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the child ceased to be a dependent on the date specified in your **Notice of Qualifying Event**, his or her COBRA continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA continuation coverage would have started. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date.

(b) Notice Procedures for Notice of Disability

(1) Deadline. The deadline for providing this notice is 60 days after the latest of:

- The date of the Social Security Administration's disability determination;

- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours.

Your **Notice of Disability** also must be provided within 18 months after the covered employee's termination of employment or reduction of hours.

- (2) Delivery.** You must mail or hand deliver this notice to:
Human Resources Department, Employer (see Section II.A for Employer address).

Your notice must be in writing (using the Plan's form described in Question and Answer VII.C.29(b)(3)) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described in Question and Answer VII.C.29(b)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer VII.C.29(b)(1).

- (3) Required Form and Information.** You must use the Plan's form "**Notice of Disability**" to notify the Employer of a qualified beneficiary's disability, and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer.)

Your notice must contain the following information:

- The name of the Plan (Cafeteria Plan, Group Insurance Premium Plan (with respect to underlying health benefits) and/or Medical Reimbursement Plan of (specify Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA continuation coverage (the covered employee's termination of employment or reduction of hours);
- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA continuation coverage at the time of the notice;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name, and contact information of the individual sending the notice.

Your **Notice of Disability** must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the Employer that does not contain all of the information and documentation required by these **Notice Procedures for Notice of Disability**, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed or hand-delivered to the individual and address specified in Question and Answer VII.C.29(b)(2);
- The notice is provided by the deadline described in Question and Answer VII.C.29(b)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Disability**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for the **Notice of Disability** described in Question and Answer VII.C.29(b)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA continuation coverage period due to the disability reported in the notice.

(c) Notice Procedures for Notice of Second Qualifying Event

(1) Deadline. The deadline for providing this notice is 60 days after the later of:

- The date of the second qualifying event (that is, a divorce or legal separation, the covered employee's death, or a child's loss of dependent status); and

- The date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

(2) Delivery. You must mail or hand deliver this notice to:
Human Resources Department, Employer (see Section II.A for Employer address).

Your notice must be in writing (using the Plan's form described in Question and Answer VII.C.29(c)(3)) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described in Question and Answer VII.C.29(c)(1). If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described in Question and Answer VII.C.29(c)(1).

(3) Required Form and Information. You must use the Plan's form "Notice of Second Qualifying Event" to notify the Employer of a second qualifying event (that is, a divorce or legal separation, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the form from the Employer).

Your notice must contain the following information:

- The name of the Plan (Cafeteria Plan, Group Insurance Premium Plan (with respect to underlying health benefits) and/or Medical Reimbursement Plan of (specify Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The initial qualifying event that started your COBRA continuation coverage (the covered employee's termination of employment or reduction of hours);
- The date that the covered employee's termination of employment or reduction of hours happened;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA continuation coverage at the time of the notice;
- The second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- The date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are notifying the Employer of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If you provide a written notice to the Employer that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- The notice is mailed or hand-delivered to the individual and address specified in Question and Answer VII.C.29(c)(2);
- The notice is provided by the deadline described in Question and Answer VII.C.29(c)(1);
- From the written notice provided, the Employer is able to determine that the notice relates to the Plan;
- From the written notice provided, the Employer is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these **Notice Procedures for Notice of Second Qualifying Event**) within 15 business days after a written or oral request from the Employer for more information (or, if later, by the deadline for this **Notice of Second Qualifying Event** described in Question and Answer VII.C.29(c)(1)).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA continuation coverage period due to the second qualifying event reported in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the Employer requests it, provide documentation of the date of the qualifying event that is satisfactory to the Employer (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Employer to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA continuation coverage.

If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the child ceased to be a dependent on the date specified in your **Notice of Second Qualifying Event**, his or her COBRA continuation coverage may be terminated

(retroactively if applicable) as of the date that COBRA continuation coverage would have ended without an extension due to loss of dependent status. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date.

If your notice was regarding the death of the covered employee, you must, if the Employer requests it, provide documentation of the date of death that is satisfactory to the Employer (for example, a death certificate or published obituary). This will allow the Employer to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA continuation coverage.

If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Employer that the date of death was the date specified in your **Notice of Second Qualifying Event**, the COBRA continuation coverage of all qualified beneficiaries receiving an extension of COBRA continuation coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA continuation coverage would have ended without an extension due to the covered employee's death. The Employer (or its designee) will require repayment to the Plan of all benefits paid after the termination date.

(d) Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

(1) Deadline. If you are providing a **Notice of Other Coverage** (a notice that a qualified beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a **Notice of Medicare Entitlement** (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a **Notice of Cessation of Disability** (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA continuation coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

(2) Delivery. You must provide these notices to:
Human Resources Department, Employer (see Section II.A for Employer address).

Your notice must be provided no later than the deadline described in Question and Answer VII.C.29(d)(1).

(3) Required Form and Information. You should use the Plan's form "**Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability**" to notify the Employer of any of

these events, and all of the applicable items on the form should be completed. You may obtain a copy of the form from the Employer.

Your notice should contain the following information:

- The name of the Plan (Cafeteria Plan, Group Insurance Premium Plan (with respect to underlying health benefits) and/or Medical Reimbursement Plan of (specify Employer));
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies);
- The qualifying event that started your COBRA continuation coverage;
- The date that the qualifying event happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are providing a **Notice of Other Coverage**, your notice should include:

- The name and address of the qualified beneficiary who obtained other coverage;
- The date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied); and
- Evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a **Notice of Medicare Entitlement**, your notice should include:

- The name and address of the qualified beneficiary who became entitled to Medicare;
- The date that Medicare entitlement occurred; and
- If available, a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a **Notice of Cessation of Disability**, your notice must include:

- The name and address of the disabled qualified beneficiary,
- The date of the Social Security Administration's determination that he or she is no longer disabled; and
- A copy of the Social Security Administration's determination.

The covered employee (that is, the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by other group health plan coverage after electing COBRA, that qualified beneficiary's COBRA continuation coverage will terminate (retroactively if applicable) as described in Question and Answer VII.C.25 regardless of whether or when a **Notice of Other Coverage** is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA continuation coverage will terminate (retroactively if applicable) as described in Question and Answer VII.C.25 regardless of whether or when a **Notice of Medicare Entitlement** is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA continuation coverage for all qualified beneficiaries whose COBRA continuation coverage is extended due to the disability will terminate (retroactively if applicable) as described in Question and Answer VII.C.25 regardless of whether or when a **Notice of Cessation of Disability** is provided.

30. Should I choose continuation coverage?

You should review the materials carefully and consult your personal advisor for advice on whether electing continuation coverage is beneficial to you.

D. PLAN AMENDMENT OR TERMINATION

1. How and when can the Plan be terminated or amended?

The Employer reserves the right to amend or discontinue the Plans at any time. Such actions will be approved by written resolution of the Employer's governing body, or by such other person or persons authorized by the governing body to take such actions. Amendments will be signed on behalf of the Employer and will be effective as of the dates specified in the amendment. Amendments may include retroactive effective dates to the extent allowed by law. However no amendment will deprive any participant or beneficiary of any right to which he or she is entitled under the affected Plans with respect to contributions previously made or provide for use of funds or assets other than for the benefit of employees and beneficiaries except as may be allowed by law or regulation. Neither the Employer nor any of its employees will have any further financial obligations hereunder from and after termination of any of the Plans except with respect to obligations that have accrued up to the date of termination which have not been satisfied. You will be notified of any such change.

2. Are there other circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits that I might otherwise reasonably expect to receive from the Plan?

Yes. Besides those circumstances mentioned above, some examples would be:

- If you were found to be ineligible to participate in the Plan, you would be ineligible for benefits (see Section II.C for more information on participation);
- Mistakes by the Employer or Plan Administrator with respect to your eligibility, contribution, reimbursement, or other aspects of the Plan, will be corrected as allowed by law; this may result, for example, in your return of an overpayment from the Plan and/or adjustment of your accounts (see Section VII.F for more information);
- If your claim for benefits is denied, your reimbursement may be affected (see Section VIII for claims procedures);
- If your salary reduction exceeds your claims, you would forfeit the portion of your account (see Sections II.E and II.G and Questions and Answers IV.8 and V.10 for more information on forfeitures); or
- If benefits are to be paid to you, but you cannot be located after reasonable efforts, the accounts may be forfeited.

There may be other circumstances which could affect the benefits you might expect to receive. If you have any questions on the above circumstances or on a specific situation not mentioned here, please see the Plan Administrator.

E. HIPAA AND OTHER FEDERAL HEALTH LAWS

1. HIPAA Notice of Preexisting Condition Exclusion

None of the Plans offered under this Summary contains direct restrictions based on preexisting conditions. However, there may be preexisting condition exclusions in underlying health plans. The existence and terms of any preexisting condition exclusion, if any, and your right to demonstrate creditable coverage and any applicable waiting periods will be covered under the terms of such plan. You may request a Certificate of Creditable Coverage from a prior plan or issuer if necessary under such prior health plan. The Plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

2. Does HIPAA portability apply (and how does that affect COBRA)?

HIPAA, the "Health Insurance Portability and Accountability Act of 1996," includes rights to special enrollment, preexisting condition exclusion limitations, participation due to special enrollment rights in a different health plan, and Certificates of Creditable Coverage. These HIPAA requirements are sometimes referred to as portability requirements to distinguish them from HIPAA privacy provisions. See Question and Answer VII.E.5 regarding privacy.

References to these HIPAA portability-type rights in this Summary generally apply only to group health plans whose premiums are paid through the Group Insurance Premium Plan and, if applicable, the Individual Billed Medical Premium Plan. HIPAA does not apply to the Dependent Care Assistance Plan.

There are special rules discussed below for the Medical Reimbursement Plan. The HIPAA requirements and references (except regarding privacy) generally will **not** apply to Medical Reimbursement Plan benefits if the following requirements are met:

- The Employer provides a separate health plan that covers major medical or other "non-excepted" benefits under HIPAA; and
- The Medical Reimbursement Plan is funded solely by your pre-tax contributions.

If these requirements are not met because, for example, the Employer contributes to your Medical Reimbursement Plan or if there is no separate health plan, it may be that the HIPAA exception does not apply. Certain Medical Reimbursement Plan benefits that meet the HIPAA exception may be subject to limited COBRA compliance (see Question and Answer VII.C.3). See the Plan Administrator for information on whether the HIPAA exception applies to you regarding the Medical Reimbursement Plan.

3. What is the HIPAA procedure for requesting a Certificate of Creditable Coverage?

If HIPAA applies and your coverage ceases, you automatically will be issued a Certificate of Creditable Coverage by the Plan or the applicable health insurance issuer, as appropriate. Also, if HIPAA applies, you or someone on your behalf may request a certificate within 24 months after coverage ends. A request must be accompanied by a written authorization if not made by you personally. See Question and Answer VII.E.2 for information about which plans are covered. Please direct requests to the Plan Administrator.

4. HIPAA Notice of Alternative Method

In the event HIPAA applies, none of the Plans use the "alternative" method of determining creditable coverage. However, the underlying health plans may or may not use the alternative method. Please consult those plan documents to determine which method is used. (The "regular" method reports creditable coverage based on all types of coverage. The "alternative" method requires reporting creditable coverage separately for mental health, dental, vision, prescription drug and substance abuse treatment coverages.)

5. What HIPAA privacy rights apply?

Under another provision of HIPAA, group health plans (including the Medical Reimbursement Plan) are required to take steps to ensure that certain "protected health information" is kept confidential.

You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

6. What are the special Federal law rules relating to hospital stays for childbirth?

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

7. Notice Regarding Coverage under the "Women's Health and Cancer Rights Act of 1998"

This Notice is provided to you as required under the Women's Health and Cancer Rights Act of 1998. It applies to you if your group health plan and the health insurance issuer provide health insurance coverage for medical and surgical benefits for a mastectomy. Under Federal law, the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), any such plan and issuer are required to provide the following coverage to a participant or beneficiary who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for physical complications of all stages of mastectomy, including lymphedemas.

This coverage must be provided in a manner determined in consultation with the attending physician and patient. The coverage is subject to any annual deductibles and coinsurance provisions that apply to your plan, as long as any deductibles and coinsurance provisions for coverage of the breast reconstruction benefits listed above are consistent with the deductibles and coinsurance for other covered benefits. Consult the group health plan summary plan descriptions for information on deductibles and coinsurance. In addition, any such plan and insurer may not:

- Deny to a patient eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of the WHCRA; or
- Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with the WHCRA.

Nothing in WHCRA prevents a group health plan or health insurance issuer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this new law or your plan.

F. MISCELLANEOUS PROVISIONS

1. Am I guaranteed employment due to my participation in the Plan?

No. Participation in the Plan is not a guarantee of employment. However, the Employer may not fire you or discriminate against you to prevent you from becoming eligible for the Plan or from obtaining a benefit or exercising your rights under ERISA.

2. What is the effect of my participation on my Social Security?

The amount of your pay which is reduced to provide benefits under the Plans is not considered wages for Social Security withholding purposes. Therefore, if your wages are less than the Social Security taxable wage base, then your participation in the Plans may cause the benefits you eventually receive from Social Security to be less than what they otherwise would be.

3. Can I assign my benefits?

You cannot assign your benefits under the Plans to anyone else. The Plan Administrator will not reimburse anyone other than you or your estate for covered expenses. It is your responsibility to arrange for payment of those expenses and then get reimbursed from the Plans. However, your benefits and coverage under the Plans may be assigned to another person providing coverage to your child pursuant to a court order that qualifies as a **Qualified Medical Child Support Order**. See Section VII.B.

4. What happens to forfeitures under the Plan?

Forfeited amounts are first used to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements to any participant in excess of the premiums paid by such participant through salary reductions. Any remaining amounts first are used to reduce the Employer's reasonable cost of administering the Plans during the Plan Year and if excess amounts remain, are used to provide increased benefits or compensation to participants in subsequent years as determined by the Plan Administrator.

5. What if the Plan cannot locate a payee?

If the Plan Administrator is unable to make payment to any participant or other person to whom a payment is due under the Plan because it cannot determine the identity or whereabouts of such participant or other person after reasonable efforts have been made to identify or locate such person,

then such payment and all subsequent payments otherwise due to such participant or other person will be forfeited following a reasonable time (as determined by the Plan Administrator) after the date any such payment first became due.

6. What if a mistake is made?

The Plan Administrator will be entitled to take certain actions in the event of a mistake as to the eligibility or participation of an employee, the allocations made to the account of any participant, or the amount of benefits paid or to be paid to a participant or other person. To the extent the Plan Administrator deems it administratively possible and permissible under Code Section 125 or the regulations issued thereunder, it will allocate, withhold, or otherwise make adjustment or recovery of such amounts. Such action by the Plan Administrator may include, but is not limited to, withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer, to the extent allowed by law.

7. Who is the Named Fiduciary and what does that mean?

To the extent ERISA applies, the Employer is the "named fiduciary" of the Plan in accordance with ERISA Section 402(a) and as such is responsible for the operation of this program for the covered employees. The Employer has full and complete authority, responsibility, discretion, and control over the management, administration, and operation of the Plan, including, but not limited to, formulation, adoption, issuance, and application of procedures and rules, and change, alteration, or amendment of such procedures and rules in accordance with the law, interpretation, and application of the provisions of the Plan, and determinations concerning eligibility for benefits. Subject to your rights explained in Section VIII, the Employer's determinations will be final, conclusive and binding on all parties as to all aspects of the Plan, including any portion of the Plan not governed by ERISA.

VIII. CLAIMS AND REVIEW PROCEDURE

A. GENERAL INFORMATION

- If your claim is for a benefit offered under any of the underlying plans or policies available through the Group Insurance Premium Plan or Individual Billed Medical Premium Plan, then you generally will proceed using the claims procedures applicable under that plan or policy.
- If a claim for reimbursement under the Medical Reimbursement Plan or Dependent Care Assistance Plan is wholly or partially denied, or if you are denied a benefit under the Plan such as the ability to pay for premiums on a pre-tax basis due to an issue relevant to your coverage under the Plan, then procedures set forth in this section apply. The claim procedures for the Plan will be administered in a manner which meets the minimum requirements of the law. If the law requires additional steps, the Plan will comply.

To obtain benefits under the Plan, you or your authorized representative must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. See the Medical Reimbursement Plan and Dependent Care Assistance Plan sections of this Summary for specific details concerning reimbursement under those Plans. Your claim for benefits begins upon the Plan Administrator's receipt of the appropriate forms (without regard to whether all the information necessary to make a benefit determination accompanies the filing).

B. RESPONSE TO INITIAL CLAIM

1. When will I learn if my claim is denied (an "adverse benefit determination")?

An "adverse benefit determination" is:

- A denial, reduction, or termination of a benefit; or
- A failure to provide or make payment (in whole or in part) for a benefit.

This includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your or your beneficiary's eligibility to participate in the Plan.

If your claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing within a reasonable period of time, but not later than 30 days after the claim is received, or within 45 days after receipt if the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that special circumstances require an extension, you will be notified in writing of any such extension within the initial 30-day period, with an explanation of the special circumstances and the date by which the Plan Administrator expects to make its decision.

If an extension is necessary because you need to submit the information required to decide your claim, the notice of extension will specifically describe the required information, and you will have 45 days from receipt of the notice to provide this information. During this time, the period for making the benefit determination will be suspended until the date on which you respond to the request for information.

2. What notification will I receive if my claim is not approved?

In the event of any adverse benefit determination, the Plan Administrator will give you, in writing:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, and, where applicable, a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. See Question and Answer VIII.D.2 for time limits on bringing an action.

If your claim is for a benefit offered by a group health plan, then, where applicable, your notice may contain information concerning any internal rules or protocols relied upon in making the determination. Additionally, and where applicable, if an adverse benefit determination is based upon medical necessity or experimental treatment, or some similar exclusions or limit, you will receive additional information on that exclusion or limit.

C. APPEAL OF ADVERSE BENEFIT DETERMINATION

1. What if I wish to appeal the Plan Administrator's decision?

If you do not agree with the decision, you or your authorized representative can request that the decision be reviewed by filing a written request for review within 180 days after receiving written notice that your claim has been denied. Under the review:

- You or your authorized representative can submit written comments, documents, records, and other information relating to the claim for benefits.
- You or your representative will receive, upon request and free of charge, reasonable access to and copies of all Plan documents, records, and other information relevant to your claim.
- All comments, documents, records, and other information submitted by you relating to the claim will be taken into account, without regard to whether such information was submitted or considered in the initial benefit determination.
- If your claim is for benefits offered by a group health plan, your appeal will be reviewed by an individual who is different from, and not subordinate to, the individual who made the initial adverse benefit determination.
- If resolution of your appeal requires a determination that is based on medical judgment, an appropriate health care professional will be consulted. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

2. When will I learn if my appeal on review is approved or denied?

The Plan Administrator will notify you of its decision in writing within a reasonable period of time, but not later than 60 days after receiving a request for review.

3. What notification will I receive of the result of my appeal?

The Plan Administrator will provide you written notification of its decision on review. Upon an adverse benefit determination after appeal, the Plan Administrator will give you, in writing:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A statement that you or your representative are entitled to receive, upon request and free of charge, reasonable access to and copies of all Plan documents, records, and other information relevant to your claim;
- For group health plan claims, if an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such criteria was relied on and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."; and
- A statement of your right, where applicable, to bring an action under ERISA Section 502(a) following an adverse benefit determination on review. See Question and Answer VIII.D.2 for time limits on bringing an action.

4. When is a document, record, or other information "relevant" to my claim?

A document, record, or other information will be considered "relevant" if it:

- Was relied upon in making a benefit determination;
- Was submitted, considered or generated in the course of making a benefit determination (without regard to whether it was relied upon in making the benefit determination);
- Demonstrates compliance with the administrative processes and safeguards in place to provide that benefit claim determinations are made in accordance with governing Plan

documents and that Plan provisions are applied consistently; or

- In the case of a group health plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

D. CLAIMS PROCEDURES/LEGAL ACTIONS

1. What if these procedures are not followed in processing my claim?

If you fail to follow claim procedures consistent with Federal requirements with respect to a benefit governed by ERISA, you would not be entitled to pursue any available remedies under an action under ERISA Section 502(a). For example, no action at law or in equity may be brought to recover benefits under the Plan until the appeal rights described in Section VII have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

If the Plan fails to follow claim procedures consistent with Federal requirements in processing your claim, you may be entitled to pursue any available remedies under an action under ERISA Section 502(a).

2. What is the time limit for taking legal action against the Plan?

Participants and beneficiaries may not take legal action against the Plan more than 1 year after the Plan Administrator's decision on review.

IX. STATEMENT OF ERISA RIGHTS

To the extent that ERISA applies to the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan And Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, if applicable, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the

operation of the Plan, including insurance contracts, and collective bargaining agreements, if applicable, and copies of the latest annual report (Form 5500 Series), if any, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if any. When applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

- If applicable, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description (see, e.g., Section VII.C) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions, if applicable, under your group health plan, if you have creditable coverage from another plan. To the extent a plan is subject to HIPAA requirements, you should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under such plan, 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 preexisting condition exclusion, to the extent provided in such plan benefit, for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants. 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.

4. Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Except as precluded by law, the Claims and Review Procedure in Section VII of this Summary describes steps that must be exhausted prior to your filing suit in a court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report, if any, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials,

unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance With Your Questions

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

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