SUMMARY PLAN DESCRIPTION
For The
Cafeteria Plan
Health Flexible Spending Account
Dependent Care Flexible Spending Account

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Wagner College

FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION ABOUT THE PLAN

Wagner College(the "Employer") is pleased to sponsor an employee benefit program known as the Flexible Benefit Plan (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to herein as "Benefit Plan Options") according to your individual needs, and allows you to use Pre-tax Contributions to pay for the benefits by entering into a salary reduction arrangement with your Employer. This Plan helps you because the benefits you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). Alternatively, you may choose to pay for any of the available benefits with After-tax Contributions on a salary deduction basis to the extent described in your enrollment materials.

This Plan has four components:

a. **A Cafeteria Plan Component**. The Cafeteria Plan Component allows you to pay your share of certain underlying welfare benefit plans (called "Benefit Plan Options") with Pre-tax Contributions.
b. **The Health Flexible Spending Account** (Health FSA). The Health FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Eligible Medical Expenses. The Health FSA is intended to qualify as a Code Section 105 self-insured medical reimbursement plan.
c. **The Dependent Care Spending Account** (Dependent Care FSA). The Dependent Care FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a Code Section 129 dependent care assistance plan.
d. **Health Savings Account** (HSA) Contributions. To the extent that Health Savings Accounts are identified as a Benefit Option in the Plan Information Summary, you may be permitted to make contributions to a Health Savings Account, as defined in Code Section 223, in accordance with the terms of the Health Savings Account Contribution Summary.

Each of the four components is summarized in this document. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary. For example, you can find the identity of the third party administrator, the Employer and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Flexible Benefit Plan. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan, how it operates and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this Summary is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

CAFETERIA PLAN COMPONENT SUMMARY

Q-1 What is the purpose of the Cafeteria Plan?

The purpose is to allow eligible employees to pay for certain benefit plans (Benefit Plan Options) with pre-tax dollars ("Pre-tax Contributions"). The Benefit Plan Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary.

To the extent Health Savings Accounts are a Benefit Plan Option under this Plan, you may be able to contribute to your personal Health Savings Account (HSA, as defined in Code Section 223) under this Plan. If you are permitted to contribute to an HSA, the rules for HSA contributions will be set forth generally in the Plan Information Summary.

Q-2 Who can participate in the Cafeteria Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who (1) satisfies the Cafeteria Plan Eligibility Requirements and (2) is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan no earlier than the Cafeteria Plan Eligibility Date. No Pre-tax Salary Reduction may be made unless a proper election is made in accordance with the terms of this SPD. The Cafeteria Plan Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. If you are eligible to participate in this Cafeteria Plan, it does not necessarily mean you are eligible to participate in the Benefit Plan Options. For details regarding eligibility provisions, benefit amounts and premium schedules for each of the Benefit Plan Options, please refer to the plan summary for each Benefit Plan Option.

Q-3 When does my participation in the Cafeteria Plan end?

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur

a. The date that you make an election not to participate in accordance with this Cafeteria Plan Summary.
b. The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan or all of the Benefit Plan Options.
c. The date that you terminate employment with the Employer.
d. The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan year or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will *automatically* cease. If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option[s]). If you are rehired or again become eligible within 30 days of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4 How do I become a Participant?

If you have otherwise satisfied the Cafeteria Plan's eligibility requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the Benefit Plan Options that you choose with Pre-tax Contributions. You will be provided with a Salary Reduction Agreement on or before your Cafeteria Plan Eligibility Date. You must complete the form and submit it to the Plan Administrator or the third party Administrator (per the instructions provided on or with your Salary Reduction Agreement) during one of the election periods described in **Q-6** below. You may also enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a Participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8** below. The election that you make under this Plan (whether to make Pre-tax Salary Reductions or not) is generally irrevocable during the Plan Year except as set for in **Q-6** below.

In some cases, the Employer may *require* you to pay your share of the Benefit Plan Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Plan Option(s) will constitute an election under this Cafeteria Plan.

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of a personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5 What are tax advantages and disadvantages of participating in the Cafeteria Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. There is an example in the Plan Information Summary that illustrates the tax savings. Cafeteria Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-6 What are the election periods for entering the Cafeteria Plan?

The Cafeteria Plan basically has three elections periods: (1) the "Initial Election Period," (2) the "Annual Election Period" and (3) the "Election Change Period", which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period.

6a. *What is the Initial Election Period?*

If you want to participate in the Cafeteria Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Cafeteria Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following pay period date that your election is received. If you are newly hired and make your election no later than thirty (30) days after your hire date, the effective date of coverage is retroactive to the hire date, if permitted by the governing documents of the Benefit Plan Options. This retroactive hire date rule does not apply to any employee who terminates employment and is rehired within 30 days after termination or returns to employment following an unpaid leave of absence of less than 30 days. Otherwise, the effective date of coverage under the Benefit Plan Options will be effective on the date established in the governing documents of the Benefit Plan Options.

The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in **Q-8** below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to Participate in this Cafeteria Plan for the remainder of the Plan Year. Failure to make an election under this Cafeteria Plan generally results in no coverage under the Benefit Plan Options; however, the Employer may provide coverage under certain Benefit Plan Options automatically. These automatic benefits are called "Default Benefits." Any Default Benefit provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a Pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such default benefits.

6b. *What is the Annual Election Period?*

The Cafeteria Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue Participation in the Cafeteria Plan with the same Benefit Plan Option elections that you had on the last day of the Plan Year in which the Annual Election Period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election." Alternatively, the Plan Administrator
may deem you to have elected not to participate in the Cafeteria Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The consequences of failing to make an election under this Cafeteria Plan during the Annual Election Period are described in the Plan Information Summary.

Special Rule for Reimbursement Accounts (and Health Savings Account contribution elections, if offered under the Plan): Evergreen elections do not apply to Reimbursement Accounts (and Health Savings Account contribution elections unless specifically stated by the employer in the enrollment material). Consequently, you generally must make an election each Annual Election Period in order to participate in the Reimbursement Accounts or to contribute to a Health Savings Account during the next Plan Year.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7 How is my Benefit Plan Option coverage paid for under this Plan?

When you elect to participate both in a Benefit Plan Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Plan Options you choose with Non-elective Employer Contributions. The amount of Non-elective Employer Contributions that is applied by the Employer towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the employer's sole discretion at any time. The Non-elective Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Non-elective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with employer contributions over which you have discretion to choose how to apply to the various Benefit Plan Options available under the Cafeteria Plan. These elective employer contributions are called "Flexible Credits" or "Benefit Credits." The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Where applicable, Salary Reduction amounts from the last month of one Plan Year may be applied to pay health plan premiums during the first month of the immediately following Plan Year, as long as your employer does this on a uniform and consistent basis with respect to all Participants.

In addition, if applicable, a terminating employee may elect to have COBRA premiums paid on a pre-tax basis from severance pay for Plan coverage.

Q-8 Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Cafeteria Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

a. You experience a "Change in Status Event" or "Cost of Coverage Change" that affects your eligibility under this Cafeteria Plan and /or a Benefit Plan Option.
b. You complete and submit a written Election Change Form within the election Change Period described in the Plan Information Summary.

Change in Status Events and Cost of Coverage Changes recognized by this Cafeteria Plan, and the rules surrounding election changes in the event you experience a Change in Status Event or Cost or Coverage Change are described in the Election Change Chart attached to this SPD. Note: If you elect to contribute to a Health Savings Account (to the extent permitted under this Plan and identified as a Benefit Plan Option in the Plan Information Summary), there are special rules regarding midyear changes to your HSA elections. The Rules regarding Health Savings Account elections (if offered under the Plan) will be set forth in the Plan Information Summary.

Third, an election under this Cafeteria Plan may be modified during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Cafeteria Plan from becoming discriminatory with the meaning of the applicable federal income tax law.

If coverage under a Benefit Plan Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9 What happens to my participation under the Cafeteria Plan if I take a leave of absence?

Your Employer may elect to continue coverage under one or more of the Benefit Options that you chose while you are absent on a paid leave. If so, you will pay your share of the cost of such coverage that you are required to pay during such a leave by the method normally used during any paid leave (for example, with Pre-tax Salary Reductions).

In the event of unpaid leave (or paid leave where coverage is not required to be continued), you will be permitted to pay your share of the cost of any such Benefit Options that you are permitted to continue during the leave in accordance with policies adopted by your Employer. The payment options offered by the Employer in accordance with such policies will be established in accordance with Code Section 125, FMLA (to the extent applicable), and any other applicable federal or state law(s) and any applicable regulations issued.

Q-10 How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11 **What happens if my request for a benefit under this Cafeteria Plan (e.g., an election change or other issue germane to Pre-tax Contributions) is denied?**

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

HEALTH FSA COMPONENT SUMMARY

Q-1 Who can participate in the Health FSA?

Each employee who satisfies the Health FSA Eligibility requirements is eligible to participate on the Health FSA Eligibility Date. The Health FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. Participation does not begin unless a proper election is made.

Q-2 How do I become a Participant?

You become a Participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health FSA will be effective on the date that you make the election or your Health FSA Eligibility Date, whichever is later. If you wish to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll midyear (see **Q-8.** of the Cafeteria Plan Summary for more details regarding midyear election changes and the effective date of those changes).

Once you become a Participant your "Eligible Dependents" also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

a. Your legal Spouse (including same-sex spouses lawfully married under state law, regardless of their state of residence).
b. Any other individuals who would qualify as a tax dependent under Code Section 105 and the regulations issued by Treasury under Code Section 106.
c. Any adult child who has not yet attained the age of 27 by the end of the current calendar year, as defined in Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the Participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE: You may be able to elect to cover only yourself under the Health FSA to the extent chosen by your Employer in the Plan Information Summary. This would allow your spouse to establish a Health Savings Account as defined in Code Section 223. If this option is available, it will be described in more detail in the Plan Information Summary. Otherwise, your participation in this Health FSA could disqualify your spouse from establishing and making/receiving tax-favored contributions to a Health Savings Account.

Q-3 What is my "Health Care Account?"

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4 When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

a. The date that you elect not to participate in accordance with the Cafeteria Plan Summary.
b. The last day of the Plan Year unless you make an election during the Annual Election Period.
c. The date that you no longer satisfy the Health FSA Eligibility Requirements.
d. The date that you terminate employment.
e. The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect Continuation Coverage (as described in **Q-16** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earlier of the following to occur:

a. The date your coverage ends.
b. The date that your Eligible Dependents cease to be eligible (e.g., you and your spouse divorce or your Eligible Dependent ages out).
c. The date the Plan is terminated or amended to exclude the individual or the class of Eligible Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your Eligible Dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5 Can I ever change my Health FSA election?

You can change your election under the Health FSA in the following situations:

a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
b. *Following a Change in Status Event.* You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8** of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes.**

Q-6 What happens to my Health Care Account if I take an approved leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7 What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-8 How are Health Care Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Q-9 What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Year, will be available at any time during the Plan Year; without regard to how much you have contributed.

Q-10 How do I receive reimbursement under the Health FSA?

Under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's third party administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the third party administrator. You must include with your Request for Reimbursement Form a written statement for an independent third party (e.g., a receipt, Explanation of Benefits [EOB], etc.) associated with each expense that indicates the following:

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

The third party administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Medical Expense you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the run-out period. The run-out period is described in the Plan Information Summary.

Reimbursement of Traditional Paper Claims will occur at least monthly or when the total amount of the claims to be submitted is at least $10.00.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

a. *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.
b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.
c. *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Health FSA will only be used for Eligible Medical Expenses (i.e., medical care expenses incurred by you, your spouse, and your Eligible Dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
d. *Health FSA reimbursement under the card is limited to health care providers (including pharmacies).* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store. (e.g., a supermarket, grocery store or discount store with a pharmacy) unless such store uses an Information Inventory Approval System as indicated below.
e. *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Health FSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source not will you seek reimbursement from another source.
f. *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

    - The nature of the expense (e.g., what type of service or treatment was provided. If the expense is for an over-the-counter drug,* the written statement must indicate the name of the drug);
    - The date the expense was incurred; and
    - The amount of the expense.

    You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the claims administrator that a third party statement is needed. You must provide the third party statement to the claims administrator within 45 days (or such longer period provided in the letter from the claims administrator) of the request.

g. *There are situations where the third party statement will not be required to be provided to the Claims Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement.

- **Co-pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided or a multiple of such co-payment(s) (up to five times the co-payment amount). For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the claims administrator.
- **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a 30 count prescription with three refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy, the receipt need not be provided to the claims administrator if the expense incurred is the same amount.
- **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the claims administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.
- **Expenses Approved Through an Information Inventory Approval System (IIAS):** When you use the electronic Payment Card at a participating merchant that uses an IIAS, the system compares the items purchased with the Card against a pre-approved list of Eligible Medical Expenses. Unapproved expenses must be purchased via other means (e.g., cash or other credit card).

Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the claims administrator does request it.

h. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the claims administrator, you must repay the Plan for the unsubstantiated expense as set forth below. The deadline for repaying the Plan is set forth in the Cardholder Agreement. In addition, if you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under either HRA. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the Employer may treat the un-reimbursed amount as a bad business debt, which could have income tax implications for you. Also, your usage of the card may be terminated by the Employer.

i. *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the Electronic Payment Card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Q-11 What is an "Eligible Medical Expense"?

a. *General Rule*

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

- The expense is for "medical care" as defined by Code Section 213(d).
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. **"Medical care" includes, but is not limited to, prescription drugs, insulin and physician-prescribed over-the-counter drugs (and over-the-counter products and devices). Over-the-counter drugs without a valid prescription by a physician are not reimbursable.** Not every health related expense you or your Eligible Dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the Code, if it is merely for the beneficial health of you and/or your Eligible Dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury or birth defect. You may, in the discretion of the third party administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of prescribed over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

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

- Health insurance premiums;
- Expenses incurred for qualified long-term care services;
- Expenses incurred for a medicine or a drug that is not prescribed by a physician, unless it is insulin. These are often referred to as over-the-counter medicines or drugs; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

b. *Limited Reimbursement Option*

You may be able to make a special election under this Health FSA to limit the scope of reimbursement that will enable you or your spouse to participate in a Health Savings Account (as defined in Code Section 223). If that option is available, it will be described in more detail in the Plan Information Summary.

Q-12 When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

There are two exceptions to this rule:

- **Orthodontia:** The Plan may reimburse you for orthodontia services before the services are provided but only to the extent that you have actually made payments in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.
- **Durable Medical Equipment:** The Plan may reimburse you for medical equipment with a useful life extending beyond the period of coverage. For example, the Plan may reimburse you for the total cost of a wheelchair even though it has a useful life beyond the Plan year in which it was purchased.

Q-13 What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the run-out period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's discretion).

Q-14 What happens if a claim for benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-15 What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Q-16 What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

<u>When Coverage May Be Continued</u>

Only Qualified Beneficiaries are eligible to elect continuation coverage if they lose coverage as a result of a qualifying event. A Qualified Beneficiary is the Employee, covered spouse and/or Eligible Dependent at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Eligible Dependent
1. Covered Employee's termination of employment or reduction in hours of employment	X	X	X
2. Divorce or legal separation		X	
3. Child ceasing to be an Eligible Dependent			X
4. Death of the covered Employee		X	X

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

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

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

Notice Requirements

You or your Spouse or your Eligible Dependents must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the later of (1) date of the event (2) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the Qualified Beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any Eligible Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g., divorce decree).

An Employee or Spouse or Eligible Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health Plan.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the election form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the first day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-elective Contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- If the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium or $50, you will be given 30 days to cure the shortfall);
- If you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- If you become entitled to Medicare; or
- If the employer no longer provides group health coverage to any of its employees.

Q-17 What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were make for expenses incurred for the care of an individual who was not a Qualifying Individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that you received an excess payment: (1) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification. (2) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement or (3) Withhold such amounts from your pay (to the extent permitted under applicable Law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (1) – (3), or if for any reason the steps in (1)-(3) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-18 Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-19 How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Q-20 How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) sponsored by the Employer?

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather that the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the Health FSA or HRA must pay first.

Q-21 Is there a grace period or is there a carryover available for my Health FSA?

The Plan allows you to carry over into a new plan year up to $500.00 **[THIS AMOUNT CANNOT BE MORE THAN $500]** of unused amounts remaining at the end of the prior plan year. This carryover does not affect the maximum amount of salary reduction contributions permitted under §125(i) of the Code. The carryover limit applies to each plan year, and you may not accumulate carryovers across multiple plan years (e.g., $500 after the first plan year, $1,000 after the second year, etc.).

Any unused amount remaining in your Health FSA as of termination of employment is forfeited (unless, if applicable, you elect and pay for COBRA continuation coverage with respect to the Health FSA).

This carryover is available even if you do not make an election for the new plan year. **[EMPLOYER OPTION]** However, in such an event, the carryover amount is available for the new plan year only.

[EMPLOYER OPTION, ONLY IF IT PLANS TO OFFER AN HSA/HDHP FOR THE NEW PLAN YEAR] If you want to contribute to an HSA in the new plan year in which the carryover is available, you may elect one of the following options in order to establish HSA eligibility immediately:

- You may waive the carryover.
- You may elect to convert your Health FSA (including carryover) to a limited purpose/post-deductible Health FSA that only reimburses dental, vision or preventive care expenses and expenses incurred after the statutory minimum annual deductible for a high-deductible health plan (HDHP).

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contract, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents will have to pay for such coverage. You should review **Q-16** of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules). You may be eligible for a reduction or elimination of exclusionary periods of coverage for a pre-existing condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the material were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1 **Who can participate in the Plan?**

Each employee who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date. The Dependent Care FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2 How do I become a Participant?

If you have otherwise satisfied the Dependent Care FSA'S Eligibility Requirements, you become a Participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Q-6** of the Cafeteria Plan Summary. Your participation in the Dependent Care FSA will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll midyear (see **Q-8** of the Cafeteria Plan Summary for more details regarding midyear election changes and the effective date of those changes).

Q-3 What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4 When does my coverage under the Dependent Care FSA end?

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

a) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
b) The last day of the Plan Year unless you make an election during the Annual Election Period;
c) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
d) The date that you terminate employment; or
e) The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Employment Related Expenses incurred after the date of separation up to the amount of your Dependent Care Account to the extent set forth in the Plan Information Summary.

Q-5 Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

b. *Following a Change in Status Event or Cost or Coverage Change.* You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant cost or coverage change. See **Q-8** of the Cafeteria Plan Summary for more information on election changes.

Q-6 What happens to my Dependent Care Account if I take an unpaid leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence.

Q-7 What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year, if you:

a. Are married and file a joint return;
b. Are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return and you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
c. Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax-free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income.

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is:

a. Physically or mentally incapable of caring for himself or herself, or
b. A full-time student (as defined by Code Section 21).

Q-8 How do I pay for Dependent Care Reimbursements?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefit Credits are available for Dependent Care FSA Coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Dependent Care Account.

Q-9 What is an "Eligible Employment Related Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Employment Related Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Employment Related Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.
2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

    a. An individual age 12 or under who (1) has the same principal place of abode as you, (2) does not provide over half of his/her own support and (3) is your "child" (son, daughter, grandchildren, stepchildren, brother, sister, niece and nephew); or
    b. A Spouse or other tax dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

    Note: There is a special rule for children of divorced parents. The child is a Qualifying Individual of the "custodial parent," as defined in Code Section 152(e).

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f) (1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 *"Your Federal Income Tax"* for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-10 How do I receive reimbursement under the Dependent Care FSA?

Under this Dependent Care FSA, you may have two reimbursement options. You can complete and submit a written claim for reimbursement ("traditional paper claim") or, alternatively, if offered with your Plan, you can use an electronic payment card to pay the expense. The following is a summary of how both options work.

Traditional Paper Claims: If you have elected to participate in the Dependent Care FSA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. The written claim form will be supplied to you. If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses – only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Reimbursement of Traditional Paper Claims will occur at least monthly or when the total amount of the claims to be submitted is at least $10.00.

If Your Employer Offers the Electronic Payment Card: The electronic payment card allows you to pay for Eligible Employment Related Expenses at the time that you incur the expense. Here is how the electronic payment card works.

a. *You must make an election to use the card.* If you wish to use an electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program (including limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.) both during the Initial Election Period and during each Annual Election Period. An electronic Payment Card Program Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Electronic Payment Card Program Agreement during the preceding Annual Election Period. The Electronic Payment Card Agreement is part of the terms and conditions of your Plan and this SPD.

b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan.

c. *You must certify proper use of the card.* As specified in the Electronic Payment Card Program Agreement, you certify during the applicable Election Period that the card will only be used for Eligible Employment Related Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. **You also certify that you will not use the card for expenses in advance of the date the services giving rise to such expenses are provided.** Failure to abide by this certification will result in termination of card use privileges.

d. *The card may be limited to certain providers.* Use of the card may be limited to certain merchants who are dependent care providers. As set forth in the Electronic Payment Card Program Agreement, you will not be able to use the card at a regular retail store.

e. *You swipe the card at the day care provider like you do any credit or debit card.* When you incur an Eligible Employment Related Expense, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available at that time you swipe the card. Every time you swipe the card, you agree to make the same certifications referenced in (c) above.

f. *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the day care provider (e.g., receipt, invoice, etc.) each time you swipe the card that includes the following information:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The dates the services giving rise to the expense were provided.
- The amount of the expense.

Even though payment is made under the electronic payment card arrangement, a written third party statement is required to be submitted to substantiate the expense. If you do not submit a written third party statement, you will receive a letter from the claims administrator that a third party statement is needed. You must provide the third party statement to the claims administrator within 45 days of the request.

g. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the claims administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, you usage of the card may be terminated by the Employer.

h. *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may submit claims under the traditional paper claims approach discussed above.

Q-11 When must the expenses be incurred in order to receive reimbursement?

Eligible Employment Related Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year and unless noted otherwise in the Plan Information Summary, after your participation in the Dependent Care FSA ends.

Q-12 What if the eligible employment related expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the run-out period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or an otherwise permitted under applicable law.

Q-13 Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregated Dependent Care Reimbursement (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-14 If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-15 What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 – 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-16 What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

Q-17 What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-18 What happens if I received erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Employment Related Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that receive an excess payment: (1) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification, (2) The Plan Administrator may offset the excess reimbursement against any other eligible Employment Related Expenses submitted for reimbursement or (3) Withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (1)–(3), or if for any reason the steps in (1)-(3) are not applied during the Plan Year that the excess reimbursement was made, the Plan administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

Q-19 How long will the Dependent Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Q-20 Is there a grace period available for my Dependent Care FSA?

Yes. **[IF GRACE PERIOD]** The grace period is a period of two months and 15 days after the end of the plan year during which the Plan will reimburse your Eligible Employment Related Expenses incurred during the grace period from your unused balance. Any remaining balance after the grace period ends is forfeited.

PLAN INFORMATION SUMMARY

This Appendix provides information specific to Wagner College. The Effective Date of this Plan Information Summary is January 1, 2018. This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.

EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

Name, address and telephone number of the Employer/Plan Sponsor	**Wagner College** **One Campus Road** **Staten Island, NY 10301** **718-390-3187**
Name, address and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies or omissions in the Plan and the SPD issued in connection with the Plan.	**Wagner College** **One Campus Road** **Staten Island, NY 10301** **718-390-3187**
Employer's federal tax identification number:	**13-5604699**
Plan number:	**501**
Effective Date of the Plan: This is the date that the Plan was first established.	**January 1, 2011**
Effective date of this SPD Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.	**January 1, 2018**
Plan year: **Short plan year:**	**January 1 through December 31**
Adopting Employers participating in the Plan:	**1.** **2.** **3.** **4.**
Third party administrator:	**Infinisource, Inc.**

II. CAFETERIA PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date.** Each Employee who is currently active and who is eligible for coverage or participation under any of the Benefit Plan Options (Cafeteria Plan eligibility requirements) will be eligible to participate in this Plan on the the first day of the month following date of hire(Cafeteria Plan Eligibility Date).

The employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in this SPD. Eligibility for coverage under any given Benefit Plan Option shall be determined not by this Plan but by the terms of that Benefit Plan Option.

(b) **Annual Election Rules.** With respect to Benefit Plan Option elections (other than the Health FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in one of the following deemed elections(s):

{N/A} The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Plan Options offered under the Plan will end the last of the Plan Year made.

{N/A} The Employee will be deemed to have elected to continue his or her Benefit Plan Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place. This is called an "Evergreen election."

(c) **Change of Election Period.** If you experience a Change in Status Event or Cost or Coverage Change as described in the Cafeteria Plan Summary and in the Election Change Chart, you may make the permitted election changes described in the Election Change Chart if you complete and submit an election change form within 30 days after the date of the event. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

(d) **Benefit Plan Options.** The Employer elects to offer to eligible Employees the following Benefit Plan Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Plan Options. These Benefit Plan Options(s) are specifically incorporated herein by reference. The maximum Pre-tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Plan Options selected reduced by any Non-elective Contributions made by the Employer. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute contributions for the state insurance law purposes.

The following Benefit Plan Options are made available under the Plan to all those eligible Employees who make an appropriate election.

1. Health Care Flexible Spending Account
2. Dependent Care Assistance Program
3.
4.

Special Rule for Health Savings Accounts (if identified above as a benefit plan option):

The following describes your rights and obligations concerning contributions made under this Plan to your Health Savings Account (as defined in Code Section 223).

Q-1. What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account ("HSA") is a personal savings account established with a custodian or trustee to be used primarily for reimbursement of "eligible medical expenses" you (the Account Beneficiary) and your Eligible Dependents (as defined in Code Section 152) incur, as set forth in Code Section 223. The HSA is administered by the HSA custodian or trustee or its designee and the terms of the HSA are set forth in the custodial or trust agreement. The HSA is not an Employer sponsored employee benefit plan. The Employer's role with respect to the HSA if limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through Non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited in the Account Beneficiary's HSA. As such, the HSA identified in the Plan Information Summary is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Q-2. Who is eligible for an HSA?

Only individuals who satisfy the following conditions are eligible for an HSA offered under this Plan:

(a) You are enrolled in a qualifying High Deductible Health Plan maintained by your Employer that is identified as a benefit plan option in the Plan Information Summary;
(b) You have opened an HSA with the custodian chosen by the Employer;
(c) You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage. (Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not [including but not limited to coverage maintained by your spouse's employer] and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223) and
(d) You have certified that you are otherwise eligible to participate in the HSA (i.e., you: 1) cannot be claimed as a tax dependent; 2) are not enrolled in Medicare coverage; 3) have qualifying high deductible health plan coverage; and 4) have no disqualifying coverage from any other source); and
(e) You are otherwise eligible for this Plan.

Q-3. Who is an account beneficiary?

An account beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable custodial agreement.

Q-4. Who is a custodian or trustee?

The custodian or trustee is the entity with whom the account beneficiary's HSA is established (for purposes of this Plan, use of the term "custodian" includes a reference to both custodian and Trustee). The HSA is not sponsored by or maintained by the Employer. The custodian or its designee will provide each account beneficiary with a custodial agreement and other information that describes how to enroll in the HSA and your rights and obligations under the HSA. The Employer may choose to restrict contributions made through this Plan to HSA's maintained by a particular custodian; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the custodial agreement).

Q-5. What are the rules regarding contributions made to an HSA under the Plan?

Contributions made under this Plan may consist of both employee Pre-tax Contributions made pursuant to a Salary Reduction Agreement and/or Non-elective Employer contributions (if any). You may elect to contribute an amount to the HSA that you wish, however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer Non-elective and Pre-tax salary reductions) during the Plan Year cannot exceed the maximum amount set for in Code Section 223(b)(2) (as adjusted for inflation).

If the account beneficiary is age 55 or older and properly certifies his age to the Employer, the maximum contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b) (3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the custodian.

To the extent set forth in the Plan's enrollment material or the HSA communication material, the Employer may automatically withhold Pre-tax Contributions from your compensation to contribute to an HSA unless you affirmatively indicate that you do not wish to contribute to the HSA with Pre-tax Contributions. Pre-tax Contributions will equal the maximum annual contribution amount set forth above (reduced by any Employer Non-elective Contributions) divided by the number of pay periods remaining during the Plan Year. Non-elective Employer Contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer) and communicated in Plan or HSA enrollment materials.

Your HSA election under this Plan will not be effective until the later of the date that you make your election or the date that you establish your HSA. The Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

Any Pre-tax Contributions that cannot be made to the HSA because you have been determined to be ineligible for such contribution will be returned to you as taxable compensation or as otherwise set forth in the Plan enrollment material. Any Non-elective Contributions that cannot be made to the HSA because the employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material.

The Employer may advance contributions to you up to your annual HSA pre-tax salary reduction election made through the Plan (reduced by any prior pre-tax contributions made by you during the Plan Year) or such other amount established by the Employer, whichever is less. Advance contributions will be made available to all Participants on non-discriminatory terms and conditions; the Employer may condition the advance of such contributions on the occurrence of certain events identified by the Employer in separate written material relating to the Plan. Moreover, you will be required to repay the Employer for advances made through this Plan through means established by the Employer.

In the event excess contributions are made to the Participant's HSA (i.e., the HSA has received contributions in excess of the Maximum Annual Contribution Amount), it will be the sole responsibility of the Participant to work with the custodian to remove the excess contribution (plus earnings on such contributions) prior to the due date of the Participant's tax return for that tax year and to report the contributions (and earnings) as income when filing taxes at the end of the year.

Q-6. What are the election change rules under this Plan for HSA elections?

You may change your HSA contribution election at least once per month during the plan year for any reason by submitting an election change form to the Plan Administrator (or its designee). Your election change will be prospectively effective as of the first day of the next pay period following the day that you properly submit your election change (or such later date as uniformly applied by the Plan Administrator to accommodate payroll changes). Your ability to make Pre-tax Contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements under this Plan.

Q-7. Where can I get more information on my HSA and its related tax consequences?

For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA and distributions from the HSA), please refer to your HSA custodial agreement and/or the HSA communication material provided by your Employer.

Special rule for vacation buy/sell benefits (if offered under the Plan).

Employees may elect to buy up to 0 vacation days in addition to the vacation days provided by the employer. In addition, employees may elect to sell up to 0 accrued vacation days in exchange for taxable compensation (such compensation will be prorated by the number of paychecks in the Plan Year and such amount will be included in each paycheck). All elections to purchase or sell vacation days must be made in accordance with the Plan's election procedures. If you buy vacation days or choose not to sell vacation days in accordance with the Employer's policies, then you must use the days you purchased or could have sold by the date established by the Employer (but in no event after the end of the Plan Year) or you will lose them. You will receive the value of unused elective vacation days in your paycheck at the end of the year. In determining whether you have unused elective vacation days, all non-elective vacation days provided by the Employer will be deemed to be used first. You will not receive cash for any unused non-elective vacation days except as otherwise provided pursuant to the Employer's internal policies and procedures.

III. HEALTH FSA COMPONENT INFORMATION

(a) **Health FSA eligibility Requirements and Eligibility Date.** Each Employee who is currently active is eligible to participate in the Health FSA on the the first day of the month following date of hire.

(b) **Annual Health Care Reimbursement Amounts.** The maximum annual reimbursement amount each year may not exceed the lesser of the Health FSA reimbursement amount elected for that year or $2,650.00. The minimum reimbursement amount that may be elected under the Health FSA is $0.00. Notwithstanding the previous sentences, for plan years starting on or after January 1, 2013, the annual salary reduction contribution limit for the Health FSA shall be subject to Code §125(i), including an annual cost-of-living adjustment as published by the IRS for later plan years.

(c) **Run-out Period.** The run-out period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

1. The run-out period for active employees ends 90 days after plan year ends.
2. The run-out period for terminated employees ends 90 days after termination date.

(d) **COBRA Administrator.** The COBRA administrator for the Health FSA is **N/A.**

(e) **Interaction with HRA.** See below regarding this Health FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	No
Does this Health FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health FSA?	N/A

(f) **Method of Funding.** Health FSA benefits are paid from general assets.

(g) **Limited Reimbursement Option.**

Does the Employer offer a limited reimbursement option under the Health FSA?	No **If "Yes", the following rules apply.**

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA Participant will not be able to make/receive tax favored contributions to a Code Section 223 Health Savings Account unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (as determined in the sole discretion of the Plan Administrator):

a. Services or treatments for dental care (excluding premiums).
b. Services or treatments for vision care (excluding premiums).

c. Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulation. This may include any prescription or over-the-counter drugs to the extent such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic), (2) to prevent the recurrence of a condition from which the eligible individual has recovered or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

A Health FSA Participant may make an election during the annual enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to medical expenses described above. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

(h) **Self-only Election.**

Does the Employer offer a self-only election under the Health FSA?	No **If "Yes," the following rule applies.**

Your participation in this Health FSA could disqualify your spouse from establishing a Health Savings Account as defined in Code Section 223 or from making/receiving tax favored contributions to the Health Savings Account (unless you have elected the limited reimbursement option set forth above). If a spouse maintains a Code Section 223 Health Savings Account or wishes to establish a code Section 223 Health Savings Account, the Health FSA Participant may make an election during the initial enrollment period and/or the annual enrollment period to exclude all family members from coverage and cover only the Participant. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

IV. DEPENDENT CARE FSA COMPONENT INFORMATION

(a) **Dependent Care FSA Eligibility Requirements and Eligibility Dates.**

Each Employee who is currently active is eligible to participate in the Dependent Care FSA on the the first day of the month following date of hire.

(b) **Run-out Period.**

The run-out period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

1. The run-out period for active employees ends after plan year ends 90 days.
2. The run-out period for terminated employees ends 90 days after termination date.

(c) **Expense Incurred After Termination of Employment.**

You may not be reimbursed for Eligible Employment Related Expenses incurred after you terminate employment up to the amount in your account balance, subject to the reimbursement rules set forth in the SPD.

(d) **Method of Funding.**

Dependent Care FSA Benefits are paid from general assets.

APPENDIX I - CLAIMS REVIEW PROCEDURE CHART

The effective date of this Appendix I is January 1, 2018. It should replace and supersede any other Appendix I with an earlier date.

The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan. The Procedure set forth below does not apply to benefit claims filed under the Benefit Plan Options other than the Health FSA and Dependent Care FSA.

Step 1. *Notice is received from third party administrator.*

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

Step 2. *Review your notice carefully.*

Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

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

Step 3. *If you disagree with the decision, file an appeal.*

If you do not agree with the decision of the third party administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4. *Notice of denial is received from third party administrator.*

If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the third party administrator.

Step 5. *Review your notice carefully.*

You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6. *If you still disagree with the third party administrator's decision, file a second level appeal with the Plan Administrator.*

If you still do not agree with the third party administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the third party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

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

APPENDIX II - TAX ADVANTAGES EXAMPLE

The effective date of this Appendix II is January 1, 2018. It should replace and supersede any other Appendix II with an earlier date.

As indicated in the SPD, participating in the Plan can actually increase your take-home pay. Consider the following example:

You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the employee-only premium, plus $2,000 for family coverage under the Employer's major medical insurance plan). You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan.	If you do not participate in the Cafeteria Plan.
1. Gross income	$50,000	$50,000
2. Salary reductions for premiums	$2,400 (pre-tax)	$0
3. Adjusted gross income	$47,600	$50,000
4. Standard deduction	($9,700)	($9,700)
5. Exemptions	($9,300)	($9,300)
6. Taxable income	$28,600	$31,000
7. Federal income tax (Line 6 x applicable tax schedule)	($3,590)	($3,590)
8. FICA tax (7.65% x Line 3 amount	($3,641)	($3,825)
9. After tax contributions	($0)	($2,400)
10. Pay after taxes and contributions	$40,365	$39,981
11. Take-home pay difference	$544	

APPENDIX III - ELECTION CHANGE CHART

The effective date of this Appendix III is January 1, 2018. It should replace and supersede any other Appendix III with an earlier date.

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Plan Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Plan Option, no election change is permitted under the Plan. Likewise, a Benefit Plan Option may allow an election change that is not permitted by this Plan. In that case, your pre-tax reduction may not be changed even though a coverage change is permitted. For a description of the election change rules for Health Savings Accounts (if made available through the Plan), see the Health Savings Account Contribution Appendix.

First, we describe the general rules regarding election changes that are established by the IRS. Then, you should look to the chart to determine under what circumstances you are permitted to make an election change under this Plan and the scope of the changes you may make.

1. **Change in Status.**

Election changes may be allowed if a Participant or a Participant's Spouse or Eligible Dependent experiences one of the Change in Status Events set forth in the chart. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated third party administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the third party administrator, but it may be earlier depending on the Employer's internal policies or procedures). A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Eligible Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements:

Loss of Dependent Eligibility. For accident and health benefits (e.g., health, dental and vision coverage), the election change must be consistent with the Change in Status. This applies to a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Eligible Dependent or an Eligible Dependent ceasing to satisfy the eligibility requirements for coverage. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of an Eligible Dependent. Contact the third party administrator for more information.

Example: Employee Mike is married to Sharon, and they have one child. Mike elects family coverage for himself, his wife Sharon and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility while the child is still eligible for coverage under the plan. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon and change to employee-plus-one dependent is consistent with this Change in Status.

Gain of Coverage Eligibility under another Employer's Plan. For a Change in Status in which a Participant, Spouse or Eligible Dependent gain eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

Dependent Care Reimbursement Plan Benefits. With respect to the Dependent Care FSA benefit, an election change is permitted only if (1) such change or termination is made on account and corresponds with a Change in Status that affects eligibility for coverage under the Plan: or (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

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

Group Term Life Insurance, Disability Income or Accidental Death and Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plan Options offered under the Plan). For group term life insurance, disability income and accidental death and dismemberment benefits only if a Participant experiences a Change in Status (as described above), an election to either increase or decrease coverage is permitted.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group term life insurance coverage (and other benefits) through salary reduction. Before the plan year, Mike elects $10,000 of group term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.**

If a Participant, Participant's Spouse and/or Eligible Dependent are entitled to special enrollment rights under a Benefit Plan Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan summary description for an explanation of special enrollment rights.

Example: Employee Mike is married to Sharon. He declines enrollment in medical coverage for himself, Sharon and one child because of outside medical coverage. They then lose coverage due to certain reasons (e.g., legal separation, divorce, death, termination of employment, reduction in hours or exhaustion of COBRA period). Mike may now elect medical coverage under the Plan for himself, Sharon and the child. Furthermore, Mike gains a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, he may also be able to enroll himself, his Spouse and the newly acquired Dependent, provided that a request for enrollment is made within the Election Change Period.

3. **Certain Judgments, Decrees and Orders.**

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

4. **Entitlement to Medicare or Medicaid.**

If a Participant or the Participant's Eligible Dependents become entitled to Medicare or Medicaid, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Eligible Dependents who have been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.

5. **Change in Cost.**

If the cost of a Benefit Plan Option significantly increases, a Participant may choose to make an increase in contributions, revoke the election and receive coverage under another Benefit Plan Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists.* If the cost of a Benefit Plan Option significantly decreases, a Participant who elected to participate in another Benefit Plan Option may revoke the election and elect to receive coverage provided under the Benefit Plan Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Plan Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plan Option options, however, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above Change in Cost exceptions are applicable to a Health FSA, to the extent offered under the Plan).

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under another health plan option.

6. **Change in Coverage.**

If coverage under a Benefit Plan Option is significantly curtailed, a Participant may elect to revoke an election and elect coverage under another Benefit Plan Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the employer or another employer), so long as (a) the other employer plan permits its Participants to make an election change permitted under the IRS regulations;: or (b) the Plan Year for

this Plan is different from the plan year of the other employer plan. Finally a Participant may change his election to add coverage under this Plan for the Participant, the Participant's Spouse or Eligible Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above Change in Coverage exceptions are applicable to the Health FSA, to the extent offered under the Plan.)

The following is a summary reflecting the election changes that may be made under the Plan with respect to each Benefit Plan Option. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Plan Options. If an election change is permitted by this Plan but not by the Benefit Plan Option, no election change under this Plan is permitted.

ELECTION CHANGE SUMMARY

I. Change in Status

A. Change in Legal Marital Status

i. Gain of Spouse (e.g., marriage)

1. **Major Medical*:*** Employee may enroll or increase election for newly eligible Spouse and Eligible Dependents. Under "tag-along" rule, new and preexisting Eligible Dependents may be enrolled. Coverage option (e.g., HMO to PPO) change may be made. Employee may revoke or decrease Employee's or Eligible Dependent's coverage only when such coverage becomes effective or is increased under the Spouse's plan.
2. **Dental and Vision*:*** Same as Major Medical.
3. **Health FSA*:*** Employee may enroll or increase election for newly eligible Spouse or Eligible Dependents.
4. **Dependent Care FSA*:*** Employee may enroll or increase to accommodate newly eligible Qualifying Individuals or decrease or cease coverage if new Spouse is not employed or makes a Dependent Care FSA coverage election under Spouse's plan.
5. **Employee Group Life, AD &D and Disability Coverage*:*** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Loss of Spouse (e.g., divorce, legal separation, annulment or spouse's death)

1. **Major Medical:** Employee may revoke election only for spouse. Coverage option (e.g., HMO to PPO) change may be made. Employee may elect coverage for self or Eligible Dependents that lose eligibility under spouse's plan. Under "tag-along" rule, any Eligible Dependents may be enrolled so long as at least one Eligible Dependent has lost coverage under spouse's plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease election to exclude former spouse. Employee may enroll or increase election if coverage is lost under spouse's health plan.
4. **Dependent Care FSA:** Employee may enroll or increase to accommodate newly eligible Qualifying Individuals (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because Qualifying Individuals now reside with ex-spouse).
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

B. Change in Number of Dependents

i. Gain of Dependent (e.g., birth or adoption)

1. **Major Medical: E**mployee may enroll or increase coverage for newly Eligible Dependent (and other Eligible Dependents not previously covered under "tag-along" rule). Coverage option (e.g., HMO to PPO) change may be made. Employee may revoke or decrease Employee's or Eligible Dependents coverage if employee becomes eligible under spouse's plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA*:*** Same as Major Medical.

4. **Dependent Care FSA:** Employee may enroll or increase coverage to accommodate newly eligible Qualifying Individuals (and any other Qualifying Individuals that were not previously covered under "tag-along" rule).
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Loss of Dependent (e.g., death)

1. **Major Medical:** Employee may drop coverage only for the Eligible Dependent that loses eligibility. Coverage option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease or cease election.
4. **Dependent Care FSA:** Employee may decrease or cease election.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

C. Change in Employment Status that Affects Eligibility

i. Commencement of Employment/Change in Employment Status that Triggers Eligibility

1. **For Employee:**
   - **a. Major Medical:** Employee may add coverage for Employee, Spouse or Eligible Dependents. Coverage option (e.g., HMO to PPO) change may be made.
   - **b. Dental and Vision:** Same as Major Medical.
   - **c. Health FSA:** Same as Major Medical.
   - **d. Dependent Care FSA:** Same as Major Medical
   - **e. Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

2. **For Spouse or Other Dependent:**
   - **a. Major Medical:** Employee may revoke or decrease election when a corresponding election is made to Spouse's or Eligible Dependent's coverage. Coverage option (e.g., HMO to PPO) change may be made.
   - **b. Dental and vision:** Same as Major Medical.
   - **c. Health FSA:** Employee may decrease or cease election if he gains coverage under Spouse's or Dependent's plan.
   - **d. Dependent Care FSA:** Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). Employee may revoke election as to Qualifying Individual's coverage if Qualifying Individual is added to Spouse's Dependent Care FSA.
   - **e. Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Employment Termination/Change in Employment Status That Causes Loss of Eligibility (e.g., full-time to part-time status, salaried to hourly pay basis).

1. **For Employee:**
   - **a. Major Medical:** Employee may revoke or decrease election for Employee, Spouse or Eligible Dependents that lose eligibility. In addition, other

previously eligible, Eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.

b. Dental and Vision: Same as Major Medical.

c. **Health FSA:** Employee may revoke election.

d. **Dependent Care FSA:** Employee may revoke or decrease election to reflect loss of eligibility.

e. Employee Group Life, AD&D and Disability Coverage: Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

2. For Spouse or Other Dependent:

a. Major Medical: Employee may enroll or increase election for Employee, Spouse or Eligible Dependents who lose eligibility under Spouse's or Dependent's employer's plan. In addition, other previously eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.

b. Dental and Vision: Same as Major Medical.

c. Health FSA: Employee may enroll or increase election if Spouse or Eligible Dependent loses eligibility for health coverage.

d. Dependent Care FSA: Employee may enroll or increase election if Spouse or Qualifying Individual loses eligibility under other employer's Dependent Care FSA. Employee may decrease or cease election if Spouse's loss of employment renders Qualifying Individuals ineligible.

e. Employee Group Life, AD&D and Disability Coverage: Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

3. Termination and Rehire of Employee:

Generally, if rehire occurs within 30 days, prior elections that were in effect at termination are reinstated unless another event has occurred that allows a change. Alternatively, employer may prohibit participation until the next plan year. If rehire occurs after 30 days, employee may make new elections.

D. Change in Employment Status that Does Not Affect Eligibility

i. An employee who was expected to average 30 hours of service or more per week in a month experiences an employment status change (such as change from full-time to part-time) such that the employee is no longer expected to average 30 hours or more per week each month

1. **Major Medical**: Employee may prospectively revoke election provided that (i) the employee makes his or her requested election change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
2. **Dental and Vision**: No change allowed.
3. **Health FSA**: No change allowed.
4. **Dependent Care FSA**: No change allowed.

5. **Employee Group Life, AD&D and Disability Coverage**: No change allowed.

E. Marketplace Eligibility

i. Employee is eligible to enroll in a Qualified Health Plan offered in the Marketplace during the Marketplace's special or annual enrollment period.

1. **Major Medical**: Employee may prospectively revoke election provided that (i) employee makes his or her change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
2. **Dental and Vision**: No change allowed.
3. **Health FSA**: No change allowed.
4. **Dependent Care FSA**: No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage**: No change allowed.

F. Change of Dependent Status

i. Newly Eligible Dependent

1. **Major Medical:** Employee may enroll or increase election for affected Eligible Dependent. In addition, other previously Eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may increase election or enroll only if Dependent gains eligibility under Health FSA.
4. **Dependent Care FSA:** Employee may increase election or enroll to take into account expenses of affected Qualifying Individual.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Newly Ineligible Dependent

1. **Major Medical:** Employee may decrease or revoke election only for affected Eligible Dependent. Cover option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease or revoke election to take into account ineligibility of expenses of affected Eligible Dependent, but only if eligibility is lost.
4. **Dependent Care FSA:** Employee may decrease or revoke election to take into account ineligibility of expenses of affected Qualifying Individual.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

G. Change in Residence

i. Move Triggers Eligibility

1. **Major Medical:** Employee may enroll or increase election for newly Eligible Dependent. Also, other previously eligible Dependents may be enrolled under "tag-along" rule. Cover option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Move Causes Loss of Eligibility

1. **Major Medical:** Employee may revoke election or make new election if the change in residence affects eligibility.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage***:* Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

II. Insignificant Cost Changes With Automatic Increase/Decrease in Elective Contributions (Initiated by Employer or Employee)

Note: The Plan has final authority to determine when a cost change is significant or insignificant based on a reasonable assessment of the facts and circumstances.

1. **Major Medical:** Plan may automatically increase or decrease (on a reasonable and consistent basis) affected Employees' elective contributions under the Plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage.** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

III. Significant Cost Changes

Note: The Plan has final authority to determine when a cost change is significant or insignificant bases on a reasonable assessment of the facts and circumstances.

i. Significant Cost Increase

1. **Major Medical:** Employee may increase election or revoke election and elect coverage under another benefit option providing similar coverage. If no other option providing similar coverage is available, Employee may revoke election.
2. **Dental and Vision:** Same as Major Medical
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical. A significant cost increase may include any cost change imposed by: (a) a dependent care provider who is not a relative of the employee, (b) a change in dependent care provider, or (c) a change in the hours of care of the dependent care provider.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. Significant Cost Decrease

1. **Major Medical:** Employee may decrease election or elect coverage with decreased cost while revoking election for similar coverage option. In the latter case, the "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical. A significant cost decrease may include any cost change imposed by: (a) a dependent care provider who is not a relative of the employee, (b) a change in dependent care provider, or (c) a change in the hours of care of the dependent care provider.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

IV. Significant Coverage Curtailment (e.g., significant increase in deductibles, co-payments or out–of-pocket maximums)

Note: The Plan has final authority to determine when coverage curtailment is significant or insignificant based on a reasonable assessment of the facts and circumstances.

i. Without Loss of Coverage

1. **Major Medical:** Employee may revoke election and make new prospective election for coverage under another benefit option providing similar coverage.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Election change may be made if provider or dependent care hours change.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. With Loss of Coverage

1. **Major Medical:** Employee may revoke election and make new prospective election for coverage under another benefit option providing similar coverage. Alternatively, employee may revoke election for similar coverage option.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Election change may be made if the dependent care provider or dependent care hours change.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

V. Addition or significant Improvement of Benefit Option

1. **Major Medical:** Eligible Employee (whether currently participating or not) may revoke their existing election and elect the newly added or improved option. The "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VI. Change in Coverage Under Other Employer's Plan (including Open Enrollment)

i. Other Employer's Plan Increases Coverage

1. **Major Medical:** For an election of or increase in the other employer's coverage, employee may decrease coverage or revoke election in Employer's Plan. For a revoked election of or decrease in the other employer's coverage, employee may increase coverage or make an election in Employer's Plan. During Open Enrollment under other Employer's plan, employee can make corresponding changes to Employer's Plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VII. Loss of Group Health Coverage Sponsored by Governmental or Educational Institution

1. **Major Medical:** Employee may enroll or increase election for Employee, Spouse or Eligible Dependent that loses coverage sponsored by a governmental or educational institution. The "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VIII. FMLA Leave

Note: Employees who continue coverage under FMLA may-at Employer's sole discretion-pay for coverage according to one of the following methods:

- *Prepay on a pre-tax basis (so long as the leave does not cover two plan years).*
- *Pay on an ongoing basis, as determined by Employer's FMLA policy (pre-tax if receiving salary continuation).*
- *Catch up upon returning from leave.*

i. Commencement of Leave

1. **Major Medical:** Employee can make same elections as Employee on Non-FMLA leave. In addition, Employer must allow an Employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow Employee to discontinue payment of his share of the contribution during the leave (the Employer may recover the Employee's share of contributions when the Employee returns to work). FMLA also allows an Employer to require that Employees on paid FMLA leave continue coverage if Employees on Non-FMLA paid leave are required to continue coverage.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** Employee may revoke election and make another election as provided under FMLA.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. Return from Leave

1. **Major Medical:** Employee may make a new election if coverage terminated while on FMLA leave. In addition, an Employer may require an Employee to be reinstated in his or her election upon return from leave if employees who return from a Non-FMLA paid leave are required to be reinstated in their elections.
2. **Dental and Vision:** S ame as Major Medical.

3. **Health FSA:** Same as Major Medical. Upon return, an employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced prorate for the missed contributions.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage*:*** Same as Major Medical.

IX. HIPAA Special Enrollment Rights

i. Loss of Other Health Coverage

1. **Major Medical*:*** Employee may elect coverage for Employee, Spouse or Eligible Dependent that has lost other coverage.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. Acquisition of New Dependent by Birth, Marriage, Adoption or Placement for Adoption (newly born/adopted dependents have coverage retroactive to birth/adoption date)

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Eligible Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

iii. Termination of Medicaid or CHIP Coverage.

Effective April, 1, 2009, if the employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health insurance plan (CHIP) under Title XXI of such Act and such coverage is terminated as a result of loss of eligibility, the employee must make a written request to the Plan Administrator no later than 60 days after coverage is terminated.

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

iv. Eligibility for Employment Assistance under Medicaid or CHIP.

If the employee or Eligible Dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the Major Medical Plan (including any waiver or demonstration project under Medicaid or CHIP), the employee must make a written request to the Plan Administrator no later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Eligible Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

X. COBRA and State Continuation Coverage Qualifying Events

1. **Major Medical:** Employee may increase pre-tax contributions under Employer's plan for coverage if the qualifying event occurs with respect to the Employee, Spouse or Eligible Dependents.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

XI. Judgment, Decree or Order

i. Order Requiring Employee to Cover Child (e.g., QMCSO)

1. **Major Medical:** Employee may change election to provide coverage for the child.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. Order Requiring Spouse, Former Spouse or Other Individual to Cover Child

1. **Major Medical:** Employee may change election to terminate coverage for child.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

Medicare or Medicaid

i. **Medicare or Medicaid Entitlement (i.e., enrollment) Other Than Coverage Solely for Pediatric Vaccines.**
   1. **Major Medical:** Employee may revoke an election or decrease coverage for Employee, Spouse or Eligible Dependent, as applicable.
   2. **Dental and Vision:** No change allowed.
   3. **Health FSA:** No change allowed.
   4. **Dependent Care FSA:** No change allowed.
   5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. **Loss of eligibility for Medicare or Medicaid Other Than Coverage Solely for Pediatric Vaccines.**
   1. **Major Medical:** Employee may commence or increase coverage for Employee, Spouse or Eligible Dependent, as applicable.
   2. **Dental and Vision:** No change allowed.
   3. **Health FSA:** No change allowed.
   4. **Dependent Care FSA:** No change allowed.
   5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.