of Tennessee

Summary Plan Description

FLEXIBLE SPENDING ACCOUNT (FSA)

CITY OF COOKEVILLE – OPTION 1

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

-توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید .

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

Flexible Benefits/Cafeteria Plan
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INTRODUCTION

Your Employer is pleased to announce that it has established a "flexible benefits plan" (the "Plan") for you and other eligible employees. Under this program, you will be able to choose among certain benefits that your Employer makes available. The benefits that you may choose are outlined in this Summary Plan Description ("SPD"). The SPD also tells you about other important information concerning the Plan, such as the requirements you must satisfy before you can join and the laws that protect your rights.

This Plan has two components:

(1) The pre-tax salary reduction component. Under this aspect of the Plan, your payments for certain benefits will be paid by payroll deduction before federal income or Social Security taxes are withheld.

(2) The flexible spending account ("FSA") component. Depending upon what your Employer has decided to offer, you may be able to participate in a Health Care FSA; a Dependent Care FSA and/or a Limited Purpose FSA. See the "Administrative Information Sheet" on the next page of this SPD to see which FSA Plans your Employer offers.

Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. You need to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator, which is your Employer or the Claims Administrator, which is identified in the "Administrative Information Sheet" on the next page. There may be a separate Plan document on file that contains more detail than this SPD, which you may request from your Employer. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. For ease of reference, defined terms in this SPD are capitalized. Those terms are usually defined the first time they are used. If that is not the case, check the "Definitions" section of the Plan document.

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

ADMINISTRATIVE INFORMATION SHEET

The Plan Administrator administers the FSA Plans and has the discretionary authority to interpret all FSA Plan provisions and to determine all issues arising under the FSA Plans, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of the FSA Plans shall not affect its right to later enforce that provision or any other provision of the FSA Plans. The Plan Administrator may delegate some of its administrative duties to agents.

Name of Plan: City of Cookeville Flexible Spending Account/Cafeteria Plan

Sponsoring Employer: City of Cookeville

Plan Administrator: City of Cookeville

Contact Person: Mike Davidson

Plan Administrator's Telephone Number: 931-526-9591

Plan Administrator's Employer Identification Number ("EIN"): 62-6000271

Claims Administrator: BlueCross BlueShield of Tennessee, Inc.[1]

Claims Administrator's Telephone Number: (800) 565-9140

Plan Number:

Plan Year: January 1 through December 31

Grace Period: No

Carryover: Yes

Carryover Maximum: $500

Types of FSA offered:

Maximum Health Care FSA contribution per Plan Year: $2650

Minimum Health Care FSA contribution per Plan Year: $10

Maximum Dependent Care FSA contribution per Plan Year: See Appendix B, Question #4.

Minimum Dependent Care FSA contribution per Plan Year: $0

Agent for Service of Process: Service may be made on the Administrator at the address listed above.

The financial records of the FSA Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

Type of Plan: The FSA Plans are intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder.

Type of Administration: The Administrator pays applicable benefits from the general assets of the Employer.

Funding: The FSA Plans are paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which benefits are paid.

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[1] **BlueCross BlueShield of Tennessee, Inc. is an Independent Licensee of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.**

ELIGIBILITY AND ENROLLMENT

1. When can I become a participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the eligibility requirements which are the same as those outlined in your health benefits plan. If you are a part-time Employee, you also meet the eligibility requirement. After that, the next step is to actually join the Plan on the effective date that the Employer established for all Employees. You will also be required to complete certain enrollment forms before you can enroll in the FSA Plans. If you are self-employed or your Employer is an S Corporation, you are, by law, not eligible for this or any FSA Plan if you own Two (2%) percent or more of the shares of the corporation.

2. What are the eligibility requirements for the Plan?

The eligibility requirements are the same as those described in your health benefits plan with the exception that part-time Employees are eligible for the FSA Plan (please note, the FSA Plan is not available to retirees).

You will automatically join the Plan for purposes of paying insurance premiums on a pre-tax basis once you are a participant in any of the group insurance plans, including, medical, life insurance and disability plans.

3. When is my effective date for participation in the Plan?

Your effective date for purposes of paying insurance premiums is the date you began participating in any insured plan of your employer and for the FSA Plan, it is the same as the effective date described in your health benefits plan, if you have completed an election form by that date.

4. What must I do to enroll in the Plan?

You must complete an Election Form to participate in the Plan. The Election Form includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize the Employer to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

5. Do I have to re-enroll at Open Enrollment every year?

Yes, you must re-enroll in the FSA Plan during Open Enrollment in order to continue participation during the next Plan Year.

ELECTIONS AND CONTRIBUTIONS

1. When is the "election period" for the Plan?

Your election period is the same as described in your health benefits plan.

2. What benefits may I elect?

You may elect to pay for the following expenses:

- Unreimbursed health, dental and vision care expenses through the Health Care FSA.
- Unreimbursed dental and vision care through the Limited Purpose FSA for Participants in a high deductible health plan.
- Dependent care expenses through the Dependent Care FSA.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide during the "election period" before you begin participation. You must decide two things. First, which FSAs you want and, second, how much should go toward each account.

4. How much of my pay may the Employer deduct for a contribution to the Plan?

Each year, using the pre-tax salary reduction component of the Plan, the Employer will automatically deduct enough of your compensation to pay for your coverage under the health benefits plan as well as other benefits under the plan that you select, such as FSA accounts. These amounts will be deducted from your pay over the course of the Plan Year.

5. What happens to contributions made to the Plan?

They will be used to pay for your Covered benefits and expenses as they arise during the Plan Year. Before each Plan Year begins, you must select the non-insured benefits you want and how much of your contribution should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year.

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." If you have a "change in status," you must notify the Administrator within Thirty (30) days after the change in order to preserve your right to change your election.

Currently, Federal law considers the following events to be "changes in status":

- marriage, divorce, death of a spouse, legal separation or annulment; or
- change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- changes in employment status of you or your spouse, including;
  - termination or commencement of employment;
  - strike or lockout;
  - commencement or return from an unpaid leave of absence;
  - change in worksite; or
  - any other change in employment status that affects eligibility for benefits;
- one of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- a change in the place of residence of you, your spouse or dependent that affects the person's coverage under a Benefit Plan.

The Federal government may change these without notice.

In addition, if you are participating in the Dependent Care Assistance Plan, then there is a

"change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

Any change in an election must be made consistent with the "change in status" resulting in the change. In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. You should contact the Administrator if any of these conditions apply to you.

If the cost of a benefit (health insurance, life insurance, Dependent Care FSA, etc.) that is paid for through the pre-tax salary reduction component of the Plan increases or decreases during a Plan Year, then the Employer will automatically increase or decrease your salary reduction election. If the cost increases significantly, you will be permitted to either: (1) make corresponding changes in your payments; (2) revoke your election and obtain coverage under another benefit package option with similar coverage, if available; or (3) revoke your election entirely.

If the coverage under a benefit (health insurance, life insurance, Dependent Care FSA, etc.) that is paid for through the pre-tax salary reduction component of the Plan is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage, if available. In addition, if the Employer adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are permitted to add coverage for a benefit you did not previously have and were not a Participant prior to the time that such a change occurs, you will be given the opportunity to join the Plan when the change takes place. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Medical FSA Plans, and you may not change your election to a Medical FSA Plan if you make a change due to cost or coverage for health benefits.

You may not change your election under the Dependent Care Assistance Plan, if applicable, if the cost change is imposed by a dependent care provider who is your relative.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. However, if you do not elect to participate in the FSA Plans during the election period before a new Plan Year begins, you will not be considered a Participant in the FSA Plans for the upcoming Plan Year.

8. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced. When you elect to redirect a

portion of your wages to the FSA Plans, it reduces the amount of contributions that you make to the Federal Social Security system as well as your Employer's contribution to Social Security on your behalf.

9. What if I take off work, pursuant to the Family and Medical Leave Act ("FMLA")?

If you take leave under the Family and Medical Leave Act you may revoke or change your existing elections for health benefits, group-term life insurance and the Medical FSA Plans. If your coverage in these benefits terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Medical Reimbursement Plan, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make up payments for the time that you are on leave. For example, if you elect One Thousand Two Hundred ($1,200) dollars for the Plan Year and are out on leave for Three (3) months beginning April 1st, then return to work on July 1st and elect to resume your coverage at that level, your remaining payments can be increased to cover the difference-from One Hundred ($100) dollars per month to One Hundred Fifty ($150) per month for the remaining six months. Alternatively your maximum amount can be reduced proportionately for the time that you were gone. For example, if you elect Twelve Thousand Two Hundred ($1,200) dollars for the Plan Year and are out on leave for three months, your annual contribution can be reduced to Nine Hundred ($900) dollars. The expenses you incur during the time you are not in the Medical FSA Plans are not reimbursable. If you continue your coverage during your FMLA leave, you may pre-pay for the coverage or you may pay for your coverage on an after-tax basis while you are on leave. For purposes of any other benefit under the Plan, such as the Dependent Care FSA, you will be treated as terminated as described in Question 11 of this Section.

10. What if I take an unpaid leave of absence other than under the FMLA?

If you take an unpaid leave of absence that is not under the FMLA, then you are generally treated as terminated for purposes of the FSA Plans and participation will cease, subject to your right to continue coverage under COBRA, and no further salary reduction contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses incurred prior to your leave. If applicable, you will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care FSA at the time of your leave if you have qualifying expenses. If you return to work within Thirty (30) days after beginning your leave, your prior elections will automatically be reinstated, otherwise, you will be permitted to make new elections under the Plan when you return to work.

11. What if I leave work to serve in the military?

If you are going into or returning from military service, you may have special rights to health care coverage under your Medical FSA Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights can include extended health care coverage under a Medical FSA Plan. If you could be affected by this law, ask your Administrator for further details.

BENEFIT PAYMENTS

1. How will I receive payments from my accounts?

Reimbursement rules may vary for different Employers' plans, but, generally speaking, funds in your FSA may be paid in one of two ways during the plan year:

(a) **Manual Submissions**. You may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay, (this is an "Approved Claim"), you will receive a reimbursement payment soon after you submit the request. Remember, the reimbursements made from the FSA Plans are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Generally, payments of benefits will be made on a weekly basis.

(b) **Automatic Reimbursements**. If your Employer offers this option, when you are treated by a health care provider for something that is covered under your health plan and the provider submits your claim for payment, the claim will automatically be processed against available funds in your FSA and, if appropriate, a check from your FSA will be sent to you.

The provisions of the benefit plans and insurance contracts will control what benefits will be paid and when. There are different reimbursement rules for different FSA Plans, so you should review the reimbursement rules applicable to your particular plan.

2. What if it turns out that the payment I received for an approved claim was more than my actual expense? For example, what if the Claims Administrator made a mistake or I paid a certain amount at the doctor's office, but once the insurance claim was processed, I owed a lesser amount?

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the FSA Plan. If you do not refund the overpayment or erroneous payment, the FSA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. In no event will an error by the Administrator or the Claims Administrator entitle you to more benefits than are otherwise due under this Plan. If failure to repay an overpayment is your fault, you must indemnify the Employer and Claims Administrator for any penalties or losses they incur as a result of the failure.

3. What happens if I don't spend all plan contributions?

In general, you will have Ninety (90) days ("Member Run-out Period") after the end of the Plan Year to file claims for expenses incurred during the Plan Year.

Your Health Care FSA allows Carryover. "Carryover" means the amount of unspent Health Care FSA funds that are available to be carried from one Plan Year into the next. Unused contributions that remain in your Health Care FSA at the end of a Plan Year may

be used to reimburse expenses incurred during the following Plan Year even if you do not elect a new Health Care FSA for the following Plan Year. IRS regulations limit Carryover to a maximum of Five Hundred ($500) dollars; however, your Employer may set a lower limit ("Carryover Maximum").

You are still required to submit claims incurred during the prior Plan Year within the Member Run-out Period after the end of the prior Plan Year, but you may carry over unused funds from the prior Plan Year (up to the Carryover Maximum) to reimburse expenses incurred in the current Plan Year. You will forfeit any unused funds over the Carryover Maximum.

Check the "Administrative Information Sheet" at the beginning of this SPD for the amount of your Carryover Maximum.

Depending on your Plan setup, it is possible that you will forfeit unused funds. Therefore, it is important that you carefully decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

4. Will I receive any statements of my Accounts?

You will be provided with an Explanation of Payment ("EOP") for each payment that is made from your FSA. You may also monitor the balance of your FSA on-line at www.bcbst.com. It is important to read your EOPs carefully and monitor your account activity so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year. You may be able to carry over unused funds, but only up to the Carryover Maximum.

5. Do limitations apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key Employees if as a group they receive more than Twenty-Five (25%) percent of all of the nontaxable benefits provided under the FSA Plans.

Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

6. What is meant by "substantiation" of claims?

Because the Plan has a pre-tax salary reduction component, the Plan Administrator is required to verify that a claim for reimbursement from an FSA account corresponds to an actual expenditure by the Participant for a qualified benefit. This verification process is also known as "substantiation." Depending on how your FSA claim is processed, the Administrator or the Claims Administrator may require that you provide documentation

proving the claim is for an eligible medical or dependent care expense. Your documentation must set forth specific information depending upon the type of FSA involved. More specific information about the substantiation process for specific types of FSAs is included in the applicable appendices to this SPD.

When claims are processed by the automatic reimbursement process (See question 1, under "Benefits Payment" above), the Claims Administrator will substantiate the claim by examining the medical provider's claim and the structure of your health benefits plan, so you should not have to submit verification documents. For claims that you submit manually, you will need to include documentation with your claim.

TERMINATION OF COVERAGE

1. What happens if I terminate employment?

If you have available funds left in your Health FSA, you are eligible to continue coverage through COBRA election. If you do not have available funds left in your Health FSA, then you are not eligible to continue coverage through COBRA.

2. Can I still seek reimbursement for my expenses?

There are only three types of expenses that a Health FSA can reimburse after coverage terminates:

1. If COBRA has NOT been elected, claims for services rendered on or before the Medical FSA coverage terminates. Claims for these expenses must be received before the end of the Member Run-Out Period.
2. If COBRA has been elected, claims for services rendered during the COBRA coverage period. You will have Ninety (90) days following the close of the COBRA coverage period to submit claims for expenses incurred during the COBRA coverage period.

If applicable, you will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Assistance Plan account at the time of termination of employment. However, no further salary reduction contributions will be made on your behalf after you terminate.

CONTINUATION OF COVERAGE

1. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of healthcare coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. 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 will not apply.

2. When Coverage May Be Continued?

Only "Qualified Beneficiaries" are eligible to elect continuation coverage. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event. A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The qualifying events that may entitle a Qualified Beneficiary to continuation coverage are:

- Termination of employment or reduction in hours: Covered Employee, covered spouse, covered dependent.
- Divorce or Legal Separation: Covered spouse.
- Child ceasing to be an eligible dependent: Covered dependent.
- Death of the covered employee: Covered spouse, covered dependent.

You generally do not have the right to elect COBRA continuation unless you have a balance in your Medical FSA Account at the time you lose coverage. You will be notified if you have the right to elect COBRA continuation coverage.

3. What type of continuation coverage is available?

For purposes of this Plan, COBRA continuation coverage applies only to the Medical FSA Plans. 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 as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Medical FSA Plans 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 Medical FSA Plans will end as of the date you would otherwise lose coverage.

4. Are there any special notice requirements for COBRA continuation coverage?

Yes, you or your covered Dependents (including your Spouse) must notify the COBRA Administrator in writing of a divorce, legal separation, or a child losing dependent status within Sixty (60) days of the later of (i) date of the event (ii) 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 Administrator is notified that one of these events has occurred, the Administrator will in turn notify you what rights you have to choose continuation coverage by sending you the appropriate election forms. Notice to your Spouse is treated as notice to any covered dependents who reside with the spouse.

5. What are the election procedures and deadlines for electing COBRA?

In order to elect continuation coverage, you must complete the election form(s) and return it to the Administrator as indicated on the form within Sixty (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 Sixty (60) day period will be considered a waiver of your continuation coverage rights.

6. What is the cost of COBRA continuation coverage?

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed One Hundred and Two (102%) percent of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due Forty-five (45) days after you make your election. Subsequent contributions are due the 1st day of each month. However, you have a Thirty (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.

7. When does continuation coverage end?

The maximum period for which coverage will generally 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, 29 or 36 months from the qualifying event. 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;
- 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.

PREMIUM EXPENSE ACCOUNT

The pre-tax salary reduction component of the Plan includes the use of a Premium Expense Account. A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that the Employer offers you. These premium expenses may include:

- Health benefit premiums under a group medical plan.
- Group term life insurance premiums.
- Dental insurance premiums.
- Accidental death and dismemberment insurance premiums.

Your Employer will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply. The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when: (1) you leave employment; (2) you are no longer eligible under the terms of any coverage; or (3) when coverage terminates.

The amount of the premium payments for the Premium Payment Account under insured plans will be automatically deducted from your pay and contributed on your behalf to pay your share of the premium payment unless you elect otherwise. For this purpose "insured benefits" include the following to the extent applicable: group health, dental, vision, life insurance, disability and other similar plans and may include a self-insured program for which the Employer pays the benefits.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

MISCELLANEOUS PLAN INFORMATION

EFFECT OF PLAN ON YOUR EMPLOYMENT RIGHTS

The FSA Plans are not to be construed as giving you any rights against the FSA Plan except those expressly described in this document. The FSA Plans are not a contract of employment between you and the Employer.

PROHIBITION AGAINST ASSIGNMENT OF BENEFITS

No Benefit payable at any time under the FSA Plans shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under our health plans, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Administrator.

ERISA RIGHTS

If this FSA Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), you have certain rights to information and documentation as summarized below. Not all plans are subject to ERISA. For example, government plans and church plans are exempt from ERISA. If you are not sure whether your Plan is subject to ERISA, check with your Plan Administrator.

1. Your Rights under ERISA

If your Plan is subject to ERISA, then, as a Participant in Plan, you are entitled to certain rights and protections ERISA provides that all Participants shall be entitled to:

(a) Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and 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. You also may obtain copies of these documents, but the Administrator or Claims Administrator may charge you a reasonable amount for the copies.

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

(c) Under some circumstance to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within Thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to One Hundred Ten ($110) dollars a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 your Plan, you should contact the Administrator or the Claims Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You will have Ninety (90) days after the end of the Plan Year to file claims for expenses incurred during the Plan Year. Any claims submitted after that time will not be considered. Claims for benefits under plans other than the FSA Plans will be reviewed in accordance with procedures contained in the policies for those plans. For expenses that are subject to automatic reimbursement (See Question 1 under "Benefits Payment" above), no manual submission of the claim is required; however, you may be asked to submit additional information in some instances. All other general claims or requests should be directed to the Administrator of our Plan. If a claim under an FSA Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If the Claims Administrator fails to respond within Ninety (90) days, your claim is treated as denied. Within Sixty (60) days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within Sixty (60) days, a written response to the appeal. (This period may be extended an additional Sixty (60) days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

- Medical Claims:

In the case of a claim for medical expenses under the Medical FSA Plans, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification to Participant of claim deficiency	15 days
Time for Participant to cure claim deficiency	45 days
Review of claim denial on appeal	60 days
File an appeal of a claim denial	180 days

The Plan Administrator or Claims Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial.

(b) Reference to the specific Plan provisions on which the denial was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review.

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have One Hundred Eighty (180) days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The period of time within which the Administrator or Claims Administrator must render a decision about an appeal will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The Administrator's review will take into account all comments, documents, records and other information submitted regardless of whether the information was previously considered on initial review. The Administrator will have discretion to deny or grant the appeal in whole or part. Such decisions shall be made in accordance with the governing Plan documents and, where appropriate, Plan provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The Administrator shall have discretion to determine which claimants are similarly situated in similar circumstances. If the claimant appeals an adverse determination under the Plan, the claimant will receive notice of the appeals decision as follows:

(a) The claimant will be notified of the determination within a reasonable period of time, but not later than Sixty (60) days after receipt of the request for review.

(b) If the decision to deny the claim was based in whole or in part on a medical judgment, the reviewing fiduciary will consult with a health care professional who has experience and training in the relevant field and who was not involved in the initial determination. Identification of any such health care professional will be provided to the claimant upon request and free of charge.

(c) Any notice of an adverse determination shall be set forth in a manner calculated to be understood by the claimant and shall include the following: (i) the specific reason or reasons for the adverse determination; (ii) reference to the Plan provisions on which the determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claimant's claim; (iv) a statement describing any voluntary appeal procedures offered by the Administrator and the claimant's right to bring an action under ERISA; and (v) if an internal rule or guideline was applied in making the determination, an explanation of the rule or a statement that the rule will be provided free of charge upon request.

No lawsuit may be brought with respect to Plan benefits until the foregoing administrative procedures have been exhausted. Additionally, no lawsuit may be brought more than One (1) year following the final adverse benefit determination of benefits under the Plan.

Appendix A

HEALTH CARE FSA[2]

The Health Care FSA enables you to pay for expenses which are not covered by the medical plan and save taxes at the same time. The account allows you to be reimbursed by the Employer for out of pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those permitted by section 213(d) of the Internal Revenue Code. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. Participants in a high deductible health plan are not eligible to participate in the Health Care FSA, but may participate in the Limited Purpose FSA Plan.

1. What is the maximum that I can contribute?

The most that you can contribute to your Health Care FSA each Plan Year is defined by the Employer and IRS guidelines**.** The maximum Health Care FSA contribution for this plan is set forth in the "Administrative Information Sheet" at the beginning of this SPD.

2. Is there a minimum I can contribute?

Yes, the minimum contribution per year is defined by your Employer. The minimum Health Care FSA contribution for this plan is set forth in the "Administrative Information Attachment".

3. What expenses qualify for reimbursement from the Health Care FSA?

Expenses that qualify for reimbursement under the Health Care FSA must meet the following requirements:

- The expense must not be covered by a health, dental or vision plan or spouse's plan.
- The expense must be included in the IRS list of eligible tax deductible expenses. A complete list may be found in IRS Publication #969. This is available on-line at http://www.irs.gov/formspubs/index.html or by calling the IRS at (800) 829-3676.
- The expenses must be incurred by you or your eligible dependents (spouse, does not include domestic partner, and any children). To qualify, the dependent must be claimed as a tax exemption on the individual's federal income tax return.

Eligible expenses can be taken either as a tax deduction on the annual federal income tax return (IRS form 1040) or used toward Health Care FSA reimbursement. An individual must select one method or the other because a deduction cannot be claimed for an expense that has been reimbursed through the FSA account.

4. Medicines or Drugs

Expenses incurred for medicines or drugs may qualify for reimbursement from the Health Care FSA only if (1) the medicine or drug requires a prescription or (2) is available without a prescription (an over-the-counter or nonprescription medicines or drugs) but the member

[2] This SPD includes appendices for three types of FSA: Health Care FSA, Dependent Care FSA and Limited Purpose FSA. Your Employer may not offer all three types of FSA. Check the Administrative Information Sheet at the beginning of the SPD to determine which FSAs are offered by your Employer.

obtains a prescription. Expenses incurred for insulin may be reimbursed from the Health Care FSA without a prescription.

Expenses must be for the treatment of an existing disease or to prevent a disease that is likely to occur if the medication is not taken. They do not include toiletries and cosmetics, vitamins and dietary supplements or herbal remedies.

4. What are some examples of ineligible expenses?

The following are examples of health care expenses which do not qualify for reimbursement:

- Health insurance premiums;
- Medicare Part B premiums;
- Vitamins;
- Marriage or family counseling;
- Custodial care in an institution; and
- Health club dues.

5. How do I receive reimbursement under the Health Care FSA?

Reimbursement rules may vary for different Employers' plans, but, generally speaking, funds in your FSA may be paid in one of three ways during the plan year:

(a) **Manual Submissions**. You may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay, (this is an "Approved Claim"), you will receive a reimbursement payment soon after you submit the request. Remember, the reimbursements made from the FSA Plans are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Generally, payments of benefits will be made on a weekly basis.

(b) **Automatic Reimbursements**. If your Employer offers this option, when you are treated by a health care provider for something that is covered under your health plan and the provider submits your claim for payment, the claim will automatically be processed against available funds in your FSA and, if appropriate, a check from your FSA will be sent to you.

6. What is the substantiation process for the Health Care FSA?

The Administrator or the Claims Administrator may require that you provide documentation proving a claim is for an eligible medical care expense. Your documentation must set forth:

- The individual(s) on whose behalf eligible medical expenses have been incurred;
- The nature and date of the eligible medical expenses so incurred;
- The amount of the requested reimbursement; and

- A statement that such eligible medical expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The documentation must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the eligible expenses have been incurred and the amounts of such eligible expenses, together with any additional documentation that the Administrator or Claims Administrator may request.

When claims are processed by the automatic reimbursement process, the Claims Administrator will substantiate the claim by examining the medical provider's claim and the structure of your health benefits plan, so you should not have to submit verification documents. For claims that you submit manually, you will need to include documentation with your claim.

Appendix B

DEPENDENT CARE FSA[3]

The purpose of the Dependent Care FSA is to provide a tax-savings program to help eligible individuals pay for work-related dependent care expenses. Expenses for a day care center or in-home child care providers may be reimbursed on a pre-tax basis through a Dependent Care FSA.

1. What expenses qualify for reimbursement?

To qualify for reimbursement from the Dependent Care FSA, dependent care expenses must be necessary for an individual (and his or her spouse, does not include domestic partner, if married) to work. The expenses must be for the well-being and protection of a qualified dependent.

2. Are there any special requirements that apply to eligible expenses?

Yes, in addition to eligibility requirements, an individual may participate in the Dependent Care FSA only if he or she has an eligible dependent and meets one of the following requirements:

- The individual is a single parent;
- The individual has a working spouse;
- The spouse is a full-time student for at least five months during the year while an individual is working;
- The spouse is disabled and unable to provide for his or her own care; or
- The individual is a divorced or legally separated parent who has child custody most of the time even though the other parent may claim the dependent for tax purposes.

3. Who are my eligible dependents?

Eligible dependents include:

- Any child under age Thirteen (13) who is claimed as a dependent for federal income tax purposes (except as provided in 2, above).
- Any other dependent who normally spends at least eight hours in the home each day and who is unable to care for himself or herself because of a physical or mental disability. The person may be a child age Thirteen (13) or over, a spouse, a parent, etc.

4. What is the maximum that I can contribute?

Under current IRS regulations, the maximum amounts an individual may contribute to the Dependent Care FSA are the following: If an individual files taxes as single or is married and files taxes jointly, the annual maximum is Five Thousand ($5,000) dollars. If an

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individual is married and files taxes separately, the annual maximum is Two Thousand Five Hundred ($2,500) dollars.

5. Is there a minimum I can contribute?

Yes, the minimum contribution per year is defined by the Employer and is set forth in the "Administrative Information Sheet" at the beginning of this SPD.

6. What are examples of eligible expenses?

An individual may be reimbursed for dependent care which is provided:

- Inside or outside the home by anyone other than a spouse, a dependent claimed on his or her income tax return, or a child under age Nineteen (19).
- In a day care center or a child care center. (If the center cares for more than six children, it must comply with state and local regulations.)
- By a housekeeper whose services include, in part, providing care for an eligible dependent.

7. What are some examples of ineligible expenses?

The following are examples of dependent care expenses which do not qualify for reimbursement:

- Expenses for food, clothing, education or entertainment, unless they are incidental and cannot be easily separated from the cost of dependent care.
- Schooling in the first grade or beyond.
- Nursing home expenses.
- Payments made to a spouse or to any person declared as a dependent for income tax purposes.

8. How do I receive reimbursement under the Dependent Care FSA?

When you incur an eligible expense, you should file a written claim with the Claims Administrator by completing and submitting a reimbursement form. Reimbursement forms may be obtained from the Claims Administrator. You must submit all claims for reimbursement for expenses during the Plan Year, and the Grace Period, if applicable, in which they were incurred.

The Claims Administrator will process the claim once it receives the request form from you. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay, (this is an "Approved Claim"), you will receive a reimbursement payment soon after you submit the request.

Dependent Care FSA reimbursements are limited to your account balance, which is equal to your year-to-date contributions. The claims administration system assumes Twenty-Six (26) pay periods during a Twelve (12) month period. Contributions are determined by taking your annual Dependent Care FSA pledge and dividing by Twenty-Six (26) pay periods. If your Employers payroll system is different you may need to check your account balance before filing a claim because there may be a delay between the date of

your contribution and the date it is credited to your account. If there are not funds available when a claim is submitted, the Claims Administrator will enter the claim into its claims processing system and as soon as additional funds are deposited, a reimbursement will be issued. If the amount of the expense was more than the account balance, the excess part of the claim will be carried over to the next pay period to be paid out as the account balance becomes adequate.

Remember, the reimbursements made from the FSA Plans are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Generally, payments of benefits will be made on a weekly basis.

9. What is the substantiation process for Dependent Care FSA claims?

When you submit a claim for reimbursement, along with the reimbursement form, you must include the following:

- The name, Social Security number or federal tax ID number of the care provider;
- The dependent's name, relationship to you, age;
- Dates of service; and
- Receipts, invoices or other documents showing the services rendered.

10. Are there other things I should consider before electing to participate in the Dependent Care FSA?

Yes. You should consult a tax adviser. The IRS permits you to take a federal tax credit on your annual income tax return for dependent care expenses. However, the amount deposited to the Dependent Care FSA will reduce, dollar-for-dollar, the amount that can be used toward the federal tax credit.

The maximum amount of dependent care expenses for purposes of the federal tax credit is Three Thousand ($3,000) dollars for One (1) dependent and Six Thousand ($6,000) dollars for more than One (1) dependent. For some individuals, the tax savings is greater if they pay for dependent care expenses through the reimbursement account. For others, it is greater if they take a tax credit on their annual income tax returns.

For more information about the federal tax credit, you can call the IRS at (800) 829-3676 and ask for Publication #503 Child and Dependent Care Expenses and for publication #596 Earned Income Credit. Publication #503 provides a list of eligible and ineligible expenses for both the tax credit and reimbursement account. You may also find these publications online at http://www.irs.gov/formspubs/index.html.

You are encouraged to consult a tax advisor if there are any questions about whether the reimbursement account or tax credit is more advantageous.

Appendix C

LIMITED PURPOSE FSA[4]

Eligible individuals who participate in a high deductible health plan ("HDHP") may elect to participate in the Limited Purpose FSA. Participants may submit claims for reimbursement for costs associated with dental and vision services to the extent not Covered by the HDHP or other insurance.

1. How do I receive reimbursement under the Limited Purpose FSA?

Reimbursement rules may vary for different Employers' plans, but, generally speaking, funds in your Limited Purpose FSA may be paid in one of three ways during the plan year:

(a) **Manual Submissions**. You may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay, (this is an "Approved Claim"), you will receive a reimbursement payment soon after you submit the request. Remember, the reimbursements made from the FSA Plans are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Generally, payments of benefits will be made on a weekly basis.

(b) **Automatic Reimbursements**. If your Employer offers this option, when you are treated by a health care provider for something that is covered under your health plan and the provider submits your claim for payment, the claim will automatically be processed against available funds in your FSA and, if appropriate, a check from your FSA will be sent to you.

2. What is the substantiation process for the Health Care FSA?

The Administrator or the Claims Administrator may require that you provide documentation proving a claim is for an eligible medical care expense. Your documentation must set forth:

- The individual(s) on whose behalf eligible medical expenses have been incurred;
- The nature and date of the eligible medical expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such eligible medical expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The documentation must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the eligible expenses have been incurred and the amounts of such eligible expenses, together with any additional documentation that the Administrator or Claims Administrator may request.

[4] This SPD includes appendices for three types of FSA: Health Care FSA, Dependent Care FSA and Limited Purpose FSA. Your Employer may not offer all three types of FSA. Check the Administrative Information Sheet of this SPD to determine which FSAs are offered by your Employer.

When claims are processed by the automatic reimbursement process, the Claims Administrator will substantiate the claim by examining the medical provider's claim and the structure of your health benefits plan, so you should not have to submit verification documents. For claims that you submit manually, you will need to include documentation with your claim.

3. What are the maximum and minimum amounts that I can contribute?

The maximum and minimum contributions for the Limited Purpose FSA are the same as for the Health Care FSA, and are found in the Administrative Information Sheet at the beginning of this SPD.

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