

# FLEXIBLE BENEFIT PLAN with Beniversal™ MasterCard® Prepaid Card

## SUMMARY PLAN DESCRIPTION

### Maximize Your Benefits

By taking advantage of this Plan, you can make your benefits more affordable and increase your spendable income. Please take the time to carefully read this summary so that you understand the advantages of participating in this valuable program.

### Take Advantage of the Tax Laws

Flexible Benefit Plans are made possible by Section 125 of the Internal Revenue Code. Congress created Section 125 to allow employees to save taxes on the money they spend on certain group insurance premiums (e.g. group health insurance), certain medical expenses not covered by insurance and certain dependent care expenses (e.g. child/adult day care).

### How the Plan Works

If you participate in the Plan, you can have money deducted from your pay tax-free to use for certain group insurance premiums. Your employer may also offer you the option of Flexible Spending Accounts, which enable you to pay eligible medical expenses not covered by insurance and eligible dependent care expenses tax-free. With Flexible Spending Accounts, you choose the amount you want to have deducted from your pay and set aside to pay for your eligible expenses.

By enrolling in the Flexible Benefit Plan, you can pay for these benefits tax-free, meaning that you will not have to pay federal income taxes, social security (FICA) taxes and most state income taxes on these amounts. Because you pay less tax, your spendable income increases.

### The Plan Saves You Money by Cutting Taxes

The following example illustrates these tax savings. Suppose your gross monthly pay is \$2,000. You pay \$200 per month for insurance premiums and you use the Plan to set aside \$25 per month in an Account for medical expense reimbursement. Based on your filing status, number of exemptions, and other deductions, assume that you pay 15% of your income in federal taxes and 5% of your income in state taxes. (Of course, your income tax rates will depend on your individual situation; the rates shown are for illustration purposes only.) Your savings can be seen by comparing your net income with and without a Flexible Benefit Plan.

<u>Monthly Pay/Expenses</u>	<u>Without Plan</u>	<u>With Plan</u>
<b>Gross Pay:</b>	<b>\$2,000</b>	<b>\$2,000</b>
<b>Less Tax-free Expenses</b>		
• Group Health Insurance:		200
• Unreimbursed Medical Costs:		25
<b>Taxable Income:</b>	<b>\$2,000</b>	<b>\$1,775</b>
<b>Less Taxes &amp; After-Tax Expenses</b>		
• Federal Income Tax at 15%:	\$300	\$266
• State Income Tax at 5%:	100	88
• FICA at 7.65%:	153	135
• Group Health Insurance:	200	
• Unreimbursed Medical Costs:	25	
<b>Net Pay:</b>	<b>\$1,222</b>	<b>\$1,286</b>

As you can see, under these facts your net pay would increase by \$64 per month (over 5%) if you join the Flexible Benefit Plan. If you do not participate, you have to pay income tax and social

security tax on the amounts you spend for health insurance premiums and out-of-pocket medical expenses. By paying for these expenses through the Plan, they do not appear as taxable income on your W-2 form, so your taxes are reduced. If you have dependent care expenses, you can use tax-free dollars to pay for them as well, which would increase your net pay even more.

### Participating in the Plan

Only those employees who are eligible to participate can enroll in the Plan. If you meet the requirements set forth in Item 4 of the Plan Highlights, you are eligible to participate. You will begin participation in the Plan on the date identified in Item 5 of the Plan Highlights.

If the Plan Administrator reasonably believes that a Participant knowingly has submitted an expense which is not eligible, the Plan Administrator may immediately discontinue the Participant's participation in the Plan, prohibit the Participant from again participating in the Plan and assess a surcharge for ineligible expenses. The Plan Administrator may request from the Participant any information reasonably necessary to assist in such determination. Failure of the Participant to provide such information shall be cause for the Plan Administrator to find that the Participant knowingly submitted an expense that is not eligible.

### Tax-Free Insurance Premiums

If you are eligible to enroll and already participate in any of the group insurance plans listed in Item 6 of the Plan Highlights, you will be automatically enrolled in the Plan, and your premiums will be deducted from your pay tax-free. However, participation is voluntary, and you may opt out of the tax-free premium feature of the Plan by signing a waiver form and returning it to the Plan Administrator prior to the date indicated in Item 5 or prior to the beginning of each new Plan Year.

If you do participate in this feature of the Plan, the amounts deducted from your pay will go directly to the applicable insurance company in payment of your premiums. The insurance company will continue to pay your benefits in accordance with the policy. Remember, participating in the Plan does not change your existing insurance coverage; it simply allows you to pay your insurance premiums tax-free.

### Tax-Free Flexible Spending Accounts (FSAs)

If you want to use the Plan to pay for eligible out-of-pocket medical expenses incurred by you or your dependents or for eligible dependent care expenses, you must enroll at the beginning of each new Plan Year in the Medical FSA and/or Dependent Care FSA by completing an enrollment form. You will use this form to indicate how much you want to designate for each type of Account, up to the maximum amounts set forth in Items 7 and 8 of the Plan Highlights. That amount will be deducted tax-free from your pay in equal installments and will go into the Account(s) you have elected. Again, you will not have to pay income tax or social security tax on the amounts set aside through the Plan for payment of these expenses.

### What Kinds of Expenses Can Be Paid Through a Medical FSA?

If you elect a Medical FSA, you can be reimbursed for many out-of-pocket medical expenses incurred by you, your spouse or your dependents. For example, deductibles, co-payments and many other items not covered by your health insurance can be reimbursed

through this Account. For a more detailed list, please refer to the Medical Expense Worksheet. (Note: Your premiums for the group insurance plans listed in Item 6 of the Plan Highlights will be automatically deducted from your pay on a tax-free basis. You cannot be reimbursed for any insurance premiums through your FSA.)

### **What Kinds of Expenses Can Be Paid Through a Dependent Care FSA?**

If you elect a Dependent Care FSA, you can be reimbursed for child or adult day care expenses, in-home dependent care expenses and nursery school expenses. In order to participate in this Account, the Internal Revenue Code requires that the following criteria be met:

- The dependent care must enable you to be gainfully employed and, if married, enable your spouse to be gainfully employed, look for work or attend school full time.
- If your dependent is a child, he or she must be less than 13 years of age.
- If your dependent is physically or mentally incapable of self-care and has the same principal place of abode as you for half of the year, he or she must spend at least 8 hours per day in your home.

These and other applicable requirements are discussed in more detail on the Dependent Care Expense Worksheet. Before you enroll in the Dependent Care FSA, you should also consider whether or not it would be to your advantage to instead use the federal tax credit for child and dependent care expenses, since you cannot claim the credit for any expenses reimbursed through this Account.

### **Deciding How Much to Set Aside in a Flexible Spending Account**

If you enroll in the Medical FSA or the Dependent Care FSA, you must carefully consider the amount you want to elect for each type of Account. Keep in mind that if your actual expenses during the Plan Year *exceed* the amount you elect, you will only be reimbursed up to the amount of your election. On the other hand, if your actual expenses during the Plan Year are *less* than the amount you elect for that purpose, the law requires that you forfeit the unused portion; this is sometimes referred to as the "use it or lose it" rule.

Because of these rules, you need to be as accurate as possible when you decide how much to elect for reimbursement. The Medical Expense Worksheet and Dependent Care Expense Worksheet can help you estimate the amount to elect for each Account.

### **Beniversal™ Cards**

If you so elect, eligible Medical and/or Dependent Care FSA expenses may be paid using a Beniversal Card at a qualified merchant. A Beniversal Card gives you the convenience of paying for eligible expenses directly, rather than having to pay the expense and then seek reimbursement. Please be sure to read the separate communication explaining the special rules and requirements that apply to your Beniversal Card.

### **How the Plan Reimburses You from Your Medical FSA and/or Dependent Care FSA**

In order to receive reimbursement for eligible expenses not purchased with the Beniversal Card, you must submit a completed Benefit Resource, Inc. claim form accompanied by the required documentation of the expense(s) being claimed. This documentation can be an itemized statement or bill from your provider or an itemized Explanation of Benefits (EOB) from your insurance carrier. For a medical claim, the documentation must clearly indicate the name of the provider, a description of the service provided, the date the service was provided and your out-of-pocket cost for the service after insurance payments have been made. For a

dependent care claim, this documentation must clearly indicate the dependent's name, the dates of service, a description of the services provided, your cost for the service and the provider's name and address.

Note that only services provided during the timeframe indicated in Item 10 of your Plan Highlights are eligible for reimbursement. Claims for reimbursement of eligible expenses must be submitted *after* the service has been provided. The IRS allows one exception: orthodontia expenses are eligible for reimbursement on either the date of payment, date of service, or payment due date on statements/coupons.

If you are enrolled in a Medical FSA, you may be reimbursed up to the full amount of your annual election less the amount of prior reimbursements for the Plan Year. If you are enrolled in a Dependent Care FSA, the amount available for reimbursement is limited to the cash balance in your Account at that time.

Claims are processed by Benefit Resource on a regularly scheduled basis as indicated in Item 9 of the Plan Highlights. Claims must be received by Benefit Resource at least 5 business days prior to the processing date and within the timeframe indicated in Item 10 in the Plan Highlights. Claims denied during this run-out period may be resubmitted, but must be received within the timeframe indicated in Item 10 of the Plan Highlights.

### **Changes During the Plan Year**

In general, once you have enrolled in the Plan, you cannot change your elections or withdraw from the Plan during that Plan Year. Your elections for any given Plan Year, subject to the exceptions below, must be made before the beginning of that Plan Year. The Plan Year begins and ends on the dates specified in Item 13 of the Plan Highlights. However, you may be permitted to prospectively change an election during a Plan Year when:

1. one of the following changes in status occurs that affects eligibility for coverage:
  - a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under this Plan or other employer plan providing the same type of benefits. (Note: If your employment terminates and resumes in the same Plan Year within a period of 30 days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.)
  - a change in your legal marital status (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
  - a change in your place of residence, or the place of residence of your spouse or dependent.
  - a change in your dependent's eligibility for coverage due to the dependent's age, student status, marital status or similar circumstance.
  - a change in the number of your dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child).
  - any other change that is a "change in status" under federal law.
2. there is a significant change in the cost of coverage. (If there is

an ordinary increase or decrease in premiums, your payroll deductions will be automatically adjusted to reflect the change. Dependent Care FSA elections cannot be changed midyear due to an increase in cost for services provided by a relative.)

3. there is a significant curtailment in or cessation of coverage (provided any curtailment of health insurance coverage must constitute reduced coverage for employees generally).
4. there is an addition or significant improvement of a benefit package option.
5. your spouse, dependent or former spouse makes a change under another plan which is either (i) a permitted mid-year election change (as described above), or (ii) made during the normal election period for the other plan and that election period is different from the Plan Year of this Plan.
6. you, your spouse or dependent loses coverage under a group health plan of a governmental or educational institution.
7. you exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
8. you, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law.
9. a court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.
10. you, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).
11. you commence or return from a statutory leave of absence.

Whenever any of the events listed above occurs, the election changes permitted are only those that conform to and are consistent with that event. See the *Election Change Overview* to determine which benefit election changes are permitted under the above circumstances. For example, a Medical FSA election cannot be changed due to an event described in paragraphs 2 through 6 above. A request to change an election due to one of the events listed above must be submitted to your Employer within the timeframe required by your Employer. Note also that participants cannot reduce FSA elections to the point where contributions are less than the amount already reimbursable for that Plan Year.

The Plan Administrator may, at any time, amend a participant's salary reduction amount for the coverage period in order to maintain compliance with nondiscrimination rules or to maintain the Plan's status under IRC Section 125.

#### **Loss of Eligibility (including termination of employment)**

If you lose eligibility during the Plan Year, your insurance coverage will continue during any period for which premium payments have already been deducted from your pay. In addition, federal law (COBRA) may give you the right to continue your health insurance at the group rate. If you lose eligibility, you will receive information about your rights to continuation of coverage from your employer.

If you are enrolled in a Medical FSA and lose eligibility during the Plan Year, you may claim reimbursement for eligible medical expenses incurred on or before your last day of eligibility. To do so, you must submit your claim for reimbursement within the timeframe specified in Item 12 of your Plan Highlights.

If your coverage terminates under your Medical FSA because of a COBRA qualifying event (e.g. termination of employment), you will be given the opportunity to continue coverage under the Medical FSA by making after-tax contributions to the Plan at the

same rate you were making contributions to the Plan before the COBRA event, plus a 2% administrative fee. You can only elect such coverage if the remaining contributions you are scheduled to make to your Medical FSA Account for the Plan Year (plus 2%) is less than the remaining medical expense reimbursements that you are entitled to receive from the Plan. If you elect COBRA coverage for your Medical FSA, the coverage will be available only for the remaining portion of the Plan Year in which the COBRA qualifying event occurs (i.e., you cannot continue it for the next Plan Year). You must make special arrangements with your employer to pay the required after-tax contributions to continue your Medical FSA Account under COBRA.

By contrast, if you are enrolled in a Dependent Care FSA and lose eligibility during the Plan Year, any funds left in this Account are available to pay eligible dependent care expenses incurred at any time during the Plan Year. You must submit your claim for reimbursement within the time limit specified in Item 12 of the Plan Highlights.

#### **Making a Decision**

In deciding whether to enroll in the Flexible Benefit Plan, you should remember that you can pick and choose among the different components of the Plan: the tax-free insurance premium feature, the Medical FSA feature, and the Dependent Care FSA feature. Before you make a decision about whether to participate in a Flexible Spending Account, please review the Medical Expense Worksheet and Dependent Care Expense Worksheet to determine whether to elect either or both of these features.

#### **Your Responsibilities**

To ensure that your benefits are paid correctly and on time, you have certain responsibilities under the Plan. You must:

- save all receipts,
- complete claim forms accurately,
- submit eligible claims in a timely manner, and
- submit any other paperwork the Plan Administrator may require.

#### **Other Things You Should Know**

The Plan Administrator will answer your questions about the Plan and provide you with any forms you need. The Plan Administrator also keeps the Plan's records and is responsible for operation of the Plan. Neither the Plan Administrator nor the employer, however, is responsible for an insurance company's failure to pay benefits. The Plan Administrator's name, address and telephone number, along with other important Plan information, are shown in Items 14 through 18 of the Plan Highlights.

The employer maintains a Plan Document on file which you may review upon request. The Plan Document is more precise than this Summary Plan Description (SPD), so if anything in this description seems to differ from the Plan Document, the Plan Document controls.

Federal law requires us to provide you with the important information contained in the following sections. Please read this information carefully and save this document, along with your Plan Highlights, Medical Expense Worksheet and Dependent Care Expense Worksheet for future reference. The section below regarding your rights under ERISA will inform you about the protection afforded to participants in this Plan under federal law. The terms or provisions of ERISA described in this summary shall apply only to the extent that the statute so requires.

The employer may amend or terminate the Plan at any time. In the event that your employer amends or terminates this Plan, you will

be notified about any changes that will affect your benefits. The Plan will use and/or disclose Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996.

### **ERISA Rights**

If you elect to participate in the Medical FSA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to that feature of the Plan. ERISA provides that all Plan participants shall be entitled to do the following:

1. Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents and copies of all documents governing the Plan, including insurance contracts and collective bargaining agreements, and, if applicable, 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.

2. Obtain, upon written request to the Plan Administrator, copies of 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 Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 a participant's Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or not addressed 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 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 up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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).

If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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, NW, Washington, DC 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.

### **Claim Denial Rights**

Claims for benefits that are insured shall be reviewed in accordance with procedures contained in the insurance policies. All other general claims or requests should be directed to the Plan Administrator. Any claim for Medical FSA or Dependent Care FSA benefits shall be made by submitting a written application to Benefit Resource. Claims for Medical FSA benefits and Dependent Care FSA benefits shall be paid in accordance with the terms of the Plan.

If any part of a claim for Medical FSA benefits is denied, Benefit Resource shall provide you with a written notice, within thirty (30) days after the receipt of the claim, setting forth: (i) the specific reasons for the denial; (ii) specific reference to the provision of this Plan upon which the denial is based; (iii) any additional information you should furnish to perfect the claim; and (iv) the steps to be taken if a review of the denial is desired. If special circumstances require it, Benefit Resource may extend the time for deciding a claim for up to an additional 15 days by providing written notice of the extension to you. If any part of a claim for Dependent Care Expenses is denied, absent special circumstances requiring an extension of time, Benefit Resource shall provide you with a written notice, within ninety (90) days after the receipt of the claim, setting forth the same items (i) through (iv).

If you would like to appeal a denial of your Medical FSA claim, you have one hundred eighty (180) days after receipt of written notice of denial in which to notify the Plan Administrator. If you would like to appeal a denial of your Dependent Care FSA claim, you must notify the Plan Administrator in writing within sixty (60) days after receipt of written notice of denial. You or your authorized representative may review any pertinent documents free of charge and submit any written issues and comments to the Plan Administrator. The Plan Administrator shall then review the claim and provide a written decision within sixty (60) days. The Plan Administrator may extend the time for rendering a decision because of special circumstances, by providing written notice of such extension to you. The Plan Administrator's written decision shall state the specific reasons for the decision, shall include reference to specific provision(s) of the Plan on which the decision is based and shall notify of your right to review (upon request and at no charge) relevant documents and other information. If your Medical FSA appeal is denied and the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with training and experience in the relevant medical field. This health care professional will not have been involved in the original denial decision, nor be supervised by the health care professional involved in the initial decision. For an appeal of a Dependent Care FSA claim, if you are not notified of the Plan Administrator's decision or of the need for an extension within 60 days, then the claim shall be deemed denied on appeal. The Plan Administrator has full discretionary authority to interpret the Plan and decide all issues relating to the Plan. Its decisions are final and binding on all parties.