RANDALL COUNTY
MEDICAL FLEXIBLE SPENDING ACCOUNT,
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT,
AND PREMIUM ONLY PLAN

Plan Document and Summary Plan Description

Effective: October 1, 2009
Restated: October 1, 2012

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AMENDMENT #1 TO: RANDALL COUNTY

FLEXIBLE BENEFIT PLAN

It is understood and agreed that:

The section entitled "Funding", subsection, "How is a qualified medical flexible spending account funded?", will be deleted in its entirety and replaced with the following:

How is a *qualified medical flexible spending account* funded?
Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed the maximum statutory amount for the calendar year for *Full-time employees,* as determined by Randall County. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the "Benefits" section.

In Witness Whereof, the undersigned has caused this amendment to be duly adopted this 1st day of October 2015, to be effective as of October 1, 2015.

By: ______________________	By: SIGNATURE ON FILE
Witness	Randall County
Date: ______________________	Date: ______________________

AMENDMENT #2 TO: RANDALL COUNTY

FLEXIBLE BENEFIT PLAN

It is understood and agreed that:

1. The section entitled "Funding", subsection, "Minimum Election Amounts", will be deleted in its entirety and replaced with the following:

   Minimum Election Amounts
   The minimum amount you must elect to contribute to your *qualified medical flexible spending account* is $100.

   There is no minimum amount you may elect to contribute to your *qualified dependent care flexible spending account*.

2. The section entitled "Salary Contribution and Discrimination", subsection "Election period for salary contribution", will be deleted in its entirety and replaced with the following:

   Election period for salary contribution
   In order to fund a *qualified medical flexible spending account, qualified dependent care flexible spending account,* or the *benefit costs* for a *premium only plan* for a *plan year*, you must complete and file with the *Plan Administrator* an appropriate *salary contribution agreement* election form as described in the section, "Eligibility for Participation." You should consider carefully the amount of salary contribution you elect for each account because you will forfeit any unused amount at the end of the *plan year.* Participants will be allowed to rollover up to $500 of unused funds at the end of the Plan Year. Failure to sign the *salary contribution agreement* election for each subsequent year will result in loss of all unused funds at the end of the *Plan Year*.

3. The section entitled "Salary Contribution and Discrimination", subsection "Termination, revocation or amendment of salary contribution elections", is hereby deleted in its entirety and replaced with the following:

   Termination, revocation, or amendment of salary contribution elections.
   Your *salary contribution agreement* election for a *plan year* will terminate at the end of the *plan year*. You must submit a signed affirmative election for a new salary contribution for each *plan year*.

   Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, "Eligibility for Participation," "May I make mid-year changes?".

In Witness Whereof, the undersigned has caused this amendment to be duly adopted this 1st day of October 2017, to be effective as of October 1, 2017.

By: ______________________________	By: SIGNATURE ON FILE
Witness	Randall County
Date: ______________________________	Date: ______________________________

PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT

What is the purpose of the *Plan*?
Randall County, (the "*Plan Sponsor*") has adopted this Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan (the "*Plan*") as set forth herein and as amended from time to time for the exclusive benefit of eligible *employees*. The purpose of this *Plan* is to allow eligible *employees* to pay eligible *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses,* and their share of premiums under the *benefit plan* ("*benefit costs*") using pre-tax dollars.

The intention of the *Plan Sponsor* is that the *Plan* qualifies as a "cafeteria plan" within the meaning of *Code* § 125 and the *Plan* shall be construed in a manner consistent with that Section. The tax implications of this *Plan*, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the *Plan Sponsor* does not represent or warrant to any *participant* that any particular tax consequence will result from participation in this *Plan*. By participating in this *Plan*, each *participant* understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the *Plan*, the recipient of the benefit will be responsible for those amounts, without contribution from the *Plan Sponsor.*

This *Plan* is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under *Code* §§ 105 and 125.

Effective date
This *summary plan description* is effective as of October 1, 2009, restated October 1, 2012, and each amendment is effective as of the date set forth therein (the "*effective date*").

Adoption of the *summary plan description*
The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* amends and replaces any prior statement of the benefits contained in the *Plan* or any predecessor to the *Plan*.

IN WITNESS WHEREOF, the *Plan Sponsor* has caused this Plan Document to be executed.

RANDALL COUNTY

SIGNATURE ON FILE
By: ____________________________________

Name: ________________________________

Date: __________________________________ Title: ___________________________________

GENERAL PLAN INFORMATION

Name of *Plan*:	**Randall County Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan**
***Plan Sponsor*:**	**Randall County 501 16th Street, Suite 302 Canyon, Texas 79015 806-477-1701**
***Plan Administrator*: (Named Fiduciary)**	**Randall County 501 16th Street, Suite 302 Canyon, Texas 79015 806-477-1701**
***Plan year*:**	**October 1 through September 30**
***Plan* Number:**	**503**
***Plan* Type:**	**Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan under *Code* §§ 106, 125, and 129**
Third party administrator:	**Insurance Management Services P. O. Box 15688 Amarillo, Texas 79105 (806) 373-5944**
***Participating employer*(s):**	**Randall County**
Agent for Service of Process:	**Randall County 501 16th Street, Suite 302 Canyon, Texas 79015 806-477-1701**

DEFINITIONS

In this section, you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this *summary plan description* for that information.**

"*Actively at work*" or "*active employment*" means performance by the *employee* of all the regular duties of his occupation at an established business location of the *participating employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor.

"*Alternate recipient*" means any child of a *participant* who is recognized under a *medical child support order* as having a right to benefits under this *Plan* as a *participant's dependent*. For purposes of the benefits provided under this *Plan*, an *alternate recipient* shall be treated as a *dependent*".

"*Annual enrollment period*" means the month of August immediately proceeding October 1 each year when eligible *employees* may enroll for participation and make elections under the *Plan* for the following *plan year.*

"*Benefit cost*" means the cost of premiums for medical, dental, vision, hearing and prescription drug coverage for a *participant*, his spouse and dependent children under the *benefit plan* that a *participant* is required, as a condition of coverage, to defray.

"*Benefit plan*" means the medical, dental, vision, hearing and prescription drug benefits provided under a group health plan established and maintained by the *Plan Sponsor*, or any successor thereto.

"*COBRA*" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"*Code*" means the Internal Revenue Code of 1986, as amended.

"*Cosmetic surgery*" means any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

"*Debit card*" means a banking card enhanced with POS (point-of-sale) features, issued by the *Plan Sponsor* to a *participant* that can be used to pay for *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* electronically.

***"Dependent*"** means any of the following individuals who meet the definition of "dependent" under Internal Revenue Code Section 152:

- Children of the *participant*;
- Stepchildren of the *participant*;

Children whose parents are divorced, legally separated, separated under a written separation agreement, or whose parents have lived apart at all times during the last six months of the calendar year, will be considered a *dependent* so long as they receive over one-half of their support from their parents and are in the custody of one or both parents for more than one-half of the calendar year.

"***Dependent care center***" means any facility which:

- Complies with all applicable laws and regulations of the state and unit of local government in which it is located;
- Provides care for more than six individuals (other than individuals who reside at the center); and
- Receives a fee, payment or grant for providing services for any of such individuals (regardless of whether such facility is operated for profit).

"***Earned income***" means the sum of the amounts set forth in the first section below, but shall exclude the amounts set forth in the second section below:

- *Earned income* includes the following:
  - Wages, salaries, tips and other employee compensation, but only if such amounts are includable as gross income for the taxable year; and
  - The amount of an *employee's* net earnings from self-employment for the taxable year (within the meaning of *Code* § 1402(a)). Such net earnings shall be determined with regard to the deductions allowed to the *employee* under *Code* § 164(f).
- *Earned income* excludes the following:
  - Amounts received under this *Plan* or any other dependent care assistance plan under *Code* § 129;
  - Amounts received as a pension or annuity (within the meaning of *Code* § 32(c)(2));
  - Amounts to which *Code* § 871(a) applies;
  - Amounts attributed to an individual pursuant to community property laws (within the meaning of *Code* § 32(c)(2));
  - Amounts attributable to wages or salary which were reduced pursuant to a written *salary contribution agreement*; and
  - Amounts received for services provided by the *participant* while the *participant* is incarcerated in a penal institution.

"***Employee***" means a person who is an employee of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-employee relationship. The term *employee* does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation. Please refer to the section, "Eligibility for Participation," for information concerning which *employees* are eligible to participate in the *Plan*.

"***FMLA***" means the Family Medical Leave Act of 1993, as amended.

"***FMLA leave***" means a leave of absence that the *participating employer* is required to extend an *employee* under the provisions of *FMLA*.

"***Health care expense***" means an expense *incurred* for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. A *health care expense* is not one that is merely beneficial to the general health of an individual.

"***HIPAA***" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"***Incurred***" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *qualified medical flexible spending expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

"***Medical child support order***" **or** "***MCSO***" means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *participant's* child or directs a *participant* to provide coverage under a health *benefit plan* pursuant to a state domestic relations law (including community property law); or

- Enforces a law relating to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.

"***National medical support notice***" **or** "***NMSN***" means a notice that contains the following information:

- The name of an issuing state agency;

- The name and mailing address (if any) of an *employee* who is a *participant* in the *Plan*;

- The name and mailing address of one or more *alternate recipients* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipient(s)*; and

- The identity of an underlying child support order.

"***Participant***" means an eligible *employee* who is participating in the *Plan.*

"***Participating employer(s)***" means Randall County.

"***Plan***" means the Randall County Medical Flexible Spending Account, Dependent Care Flexible Spending Account and Premium Only Plan.

"***Plan Administrator***" means Randall County.

"***Plan Sponsor***" means Randall County.

"***Plan year***" means the period from October 1 through September 30 each year.

"***Premium only plan***" means the vehicle through which a *participant* may elect to pay his share of *benefit costs* by reducing his salary and using pre-tax dollars,

"Prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the *health care expense* is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

"***Privacy standards***" means the final rule implementing HIPAA's Standards for Privacy of Individually Identifiable Health Information, as amended.

"***Qualified beneficiary***" means**:**

- An individual who, on the day before a *qualifying event*, is a *spouse* or *dependent* child receiving health benefits under the *plan;* or
- In the case of a *qualifying event* resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such *qualifying event*, is a *participant*.

A newborn child of, an adopted child of, or a child placed for adoption with, a *qualified beneficiary* (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the *qualified beneficiary*; however, such child shall not become a *qualified beneficiary*.

A newborn child or child placed for adoption with a *qualified beneficiary* (as defined in the second bullet above) shall become a *qualified beneficiary* in his own right and shall be entitled to benefits as a *qualified beneficiary*.

A *qualified beneficiary* must notify the *Plan Administrator* within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

"***Qualified dependent care flexible spending account***" means the account established by the *Plan Administrator* on behalf of a *participant* who elects to have amounts withheld from his salary in order to pay *qualified dependent care flexible spending expenses*.

"***Qualified dependent care flexible spending expenses***" means employment-related dependent care expenses which are eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e)(1) and 21(b). Such expenses include amounts paid for household services and for the care of *qualifying individuals* enabling the *participant* to be gainfully employed.

"***Qualified medical child support order***" **or** "***QMCSO***" means a *medical child support order* that creates or recognizes the existence of an *alternate recipient*'s right to, or assigns to an *alternate recipient* the right to, receive health benefits for which a *participant* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *qualified medical child support order*, it must clearly specify the following:

- The name and last known mailing address (if any) of a *participant* and the name and mailing address of each such *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *national medical support notice* shall be deemed a *qualified medical child support order* if it:

- Contains the information set forth above in the definition of *national medical support notice*;

- Identifies either the specific type of coverage or all available group health coverage. If the *participating employer* receives a *national medical support notice* that does not designate either specific types of coverage or all available coverage, the *participating employer* and the *Plan Administrator* will assume that all are designated;

- Informs the *Plan Administrator* that, if a group health plan has multiple options and a p*articipant* is not enrolled, the issuing agency will make a selection after the *national medical support notice* is qualified; and

- Specifies that the period of coverage may end for the *alternate recipient*(s) only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan* or upon the occurrence of certain specified events.

However, such an order need not be recognized as **"**qualified**"** if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to a *participant* and eligible *dependents*, except to the extent necessary to meet the requirements of a state law relating to *medical child support orders*, as described in Social Security Act § 1908 (as added by the Omnibus Budget Reconciliation Act of 1993 § 13822).

"*Qualified medical flexible spending account*" means the account established by the *Plan Administrator* on behalf of the *participant* through which the *participant* may elect to reduce his salary in order to pay *qualified medical flexible spending expenses.*

"*Qualified medical flexible spending expenses*" means a *health care expense* which is excludable as income according to *Code* § 105(b). *Qualified medical flexible spending expenses* are not otherwise reimbursable under the *benefit plan* or other plan or by any other entity and may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

"*Qualifying individual*" means:

- A *dependent* of a *participant* (as defined in *Code* § 152(a)(1)) who is under the age of 13;

- A *dependent* of a *participant*, regardless of age, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the *participant* for than one-half of the tax year; or

- The *spouse* of a *participant* who is physically or mentally incapable of caring for himself who has the same principal place of abode as the *participant* for than one-half of the tax year.

"*Qualifying event*" means any of the following with respect to participation in the *Plan*:

- The termination of coverage due to the death of a *participant*;

- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a *participant*;

- The divorce or legal separation of a *participant* from his *spouse*;

- A *participant's* entitlement to Medicare coverage; or

- A *dependent* child ceasing to be a *dependent* child.

"Qualified reservist distribution" means, any distribution to an individual of all or a portion of the balance in the *participant's qualified medical flexible spending account* if:

- Such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code) ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and
- Such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangements for the *plan year* that includes the date of such order or call.

"*Salary contribution agreement*" means a written agreement by a *participant* to reduce his salary or wage in order to fund a *qualified medical flexible spending account*, a *qualified dependent care flexible spending account*, or to pay *benefit costs.*

***"Security standards*"** mean the final rule implementing *HIPAA's* Security Standards for the Protection of *Electronic PHI,* as amended.

"*Spouse*" means a *participant*'s lawfully married spouse possessing a marriage license who is not divorced from the *participant.* For purposes of this section, **"**marriage or married**"** means a legal union between one man and one woman as husband and wife.

"*Student*" means an individual who, during each of five calendar months during a taxable year, is a full-time student at an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of *student*s in attendance at the place where its educational activities are regularly carried on.

"*Summary health information*" means individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan*, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

"*Summary plan description*" means this Plan Document and Summary Plan Description. This *summary plan description* represents both the Plan Document and the Summary Plan Description.

"*Third party administrator*" means Insurance Management Services.

"*Uniformed services*" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"*USERRA*" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

"*Waiting period*" means an interval of time during which the eligible *employee* is in the continuous, *active employment* of his *participating employer* before he becomes eligible to participate in the *Plan*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

You are eligible to participate in the *Plan*:

- If you are an active, full-time *employee* regularly scheduled to work at least forty (40) hours per week and you have completed a *waiting period* of at least forty-two (42) days of continuous *active employment* from your date of hire; or

If you are absent from work due to illness or a medical condition, you will be considered to be *actively at work* during that time period for the purposes of eligibility under this *Plan*.

However, you may elect to make contributions to the Premium Only Plan only if you participate in the *benefit plan.*

When will my participation begin?
If you are a new *employee*, your entry date for the *Plan* is contingent upon completion of the eligibility requirements outlined above. If you are a new *employee* who is eligible to participate, your entry date is the first date of the month following your eligibility date, provided that you have completed a *salary contribution agreement*. You must complete a proper *salary contribution agreement* within thirty (30) days from your original eligibility date in order to participate in this *Plan* for the *plan year*.

If you are enrolling during an *annual enrollment period*, your entry date will be the first date of the month following the *annual enrollment period,* provided that you have completed a *salary contribution agreement.*

By completing the *salary contribution agreement* you will be enrolling in this *Plan.* If you participate in the *benefit plan,* you may elect to reduce your salary so that your share of the premiums for the *benefit plan* are paid using pre-tax dollars. Additionally, you may elect to contribute to a *qualified medical flexible spending account* or a *qualified dependent care flexible spending account*. Eligible *employees* who do not participate in this *Plan* may not pay any required contributions to the *benefit plan* with pre-tax dollars, nor may they pay *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* using pre-tax dollars.

Unless you experience a change in circumstances, as described below, your *salary contribution agreement* will continue in force for that *plan year,* and you will be required to complete a new *salary contribution agreement* for each subsequent *plan year* for which you decide to participate in this *Plan*.

If you do not submit the *salary contribution agreement* to the *Plan Administrator* within thirty (30) days of becoming eligible, or during the *annual enrollment period*, it will be assumed that you have decided not to participate in the *Plan*, and you will not have the opportunity to enroll until the next *annual enrollment period* or following a change in status event described below.

May I elect not to participate in the *benefit plan*?
You may elect not to participate in the *benefit plan* by completing and filing an appropriate election/declination form with the *Plan Sponsor* within thirty (30) days of your original eligibility period or an *annual enrollment period*.

May I make mid-year changes in my *Plan* elections?
Generally, you cannot change your election to participate in the *Plan* or decrease or increase the amount you have elected to contribute to your account(s) once the *plan year* begins. However, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. Change in status events include:

- Marriage.
- Divorce, legal separation, or annulment.
- Birth, adoption, or placement for adoption of a child.
- Death of a *spouse* or *dependent*.
- Termination or commencement of employment by you, your *spouse*, or your *dependent*.
- Place of residence change by you, your *spouse*, or your *dependent*, which results in a change in eligibility.
- Your *dependent* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance that would make the *dependent* ineligible under *Code* § 152.
- Commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent*.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your *spouse*, or your *dependent*.
- If you, your *spouse*, or your *dependent* becomes eligible for *COBRA* continuation coverage under the *benefit plan*, you may elect to increase your contributions to the *premium only plan* or the *qualified medical flexible spending account.*

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the *Plan Administrator* within thirty (30) days of your change in status, as well as a new *salary contribution agreement* reflecting your new contribution elections. The *Plan Administrator* reserves the right to require you to submit proof of any change in status at your expense. The change in coverage becomes effective on the first day of the month following the date the written notification is received by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event. Any such change will remain in effect for the remainder of the *plan year*.

Must the election change be consistent with the change in status?
You will be permitted to change an election during the *plan year* and make a new election for the remainder of the *plan year* only if the change you make is consistent with the event. For example, you can only change your election to contribute to the *premium only plan* or the *qualified medical flexible spending account if:*

- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the *benefit plan* or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.

What if there is a change in the cost of coverage during the *plan year*?
If the *benefit costs* increase or decrease during a *plan year*, the *Plan* may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected *participant's* elective contributions for the *premium only plan*

May I continue participation during *FMLA leave*?

The Family and Medical Leave Act is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible *employee* may elect to continue coverage under this *Plan* during a period of approved *FMLA leave* at the same cost as if the *FMLA leave* not been taken.

Am I an eligible *employee*?

You are an eligible *employee* if all of the following conditions are met:

- You have been employed with the *participating employer* for at least 12 months;
- You have been employed with the *participating employer* at least 1,250 hours during the 12 consecutive months prior to the request for *FMLA leave*; and
- You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

What circumstances qualify for *FMLA leave*?

Coverage under *FMLA leave* is limited to a total of 12 work weeks during any 12-month period that follows:

- The birth of, and to care for, your *son or daughter*;
- The placement of a *child* with you for adoption or foster care;
- Your taking leave to care for your *spouse*, *son* or *daughter,* or *parent* who has a *serious health condition*; or
- Your taking leave due to a *serious health condition* which makes you unable to perform the functions of your position.
- An exigency arising out of the fact that a *spouse*, son, daughter, *parent*, or *next of kin* of the *employee* has been called to active duty in the Armed Forces in support of a contingency operation (i.e. a war or similar combat operation).

Coverage under *FMLA leave* is limited to a total of 26 work weeks during any 12-month period that follows a s*erious illness or injury* of a service member when the *employee* is that service member's primary caregiver.

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your *participating employer* has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the *Plan* contribution, if any, during the *FMLA leave*. Payment must be made within 30 days of the due date established by the *Plan Administrator*. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

What are the notice requirements for *FMLA leave*?

You must provide at least thirty (30) days notice to your *participating employer* prior to beginning any leave under *FMLA*. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your *participating employer* has the right to require medical certification to

support your request for leave due to a *serious health condition* for yourself or your eligible family members.

How long may I take *FMLA leave*?

During any one 12-month period, the maximum amount of *FMLA leave* may not exceed 12 work weeks for most *FMLA* related situations. The maximum periods for an *employee* who is the primary care giver of a service member with a *serious illness or injury* that was *incurred* in the line of active duty may take up to 26 weeks of *FMLA leave* in a single 12-month period to care for that service member. Your *participating employer* may use any of four methods for determining this 12-month period.

If you and your *spouse* are both employed by the *participating employer*, *FMLA leave* may be limited to a combined period of 12 work weeks, for both *spouses*, when *FMLA leave* is due to:

- The birth or placement for adoption or foster care of a *child*; or
- The need to care for a *parent* who has a *serious health condition*.

Will *FMLA leave* terminate before the maximum leave period?

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

- When you inform your *participating employer* of your intent not to return from leave;
- When your employment relationship would have terminated but for the leave (such as during a reduction in force);
- When you fail to return from the leave; or
- If any required *Plan* contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under *FMLA leave* ends, you will be eligible for *COBRA* continuation of coverage at that time.

Recovery of *Plan* contributions

Your *participating employer* has the right to recover the portion of the *Plan* contributions it paid to maintain coverage under the *Plan* during an unpaid *FMLA leave* if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a *serious health condition* that entitles you to *FMLA leave* (in which case your *participating employer* may require medical certification) or other circumstances beyond your control.

Will my coverage be reinstated when I return to work?

The law requires that coverage be reinstated upon your return to work following an *FMLA leave* whether or not you maintained coverage under the *Plan* during the *FMLA leave*.

On reinstatement, all provisions and limits of the *Plan* will apply as they would have applied if *FMLA leave* had not been taken. The *waiting period* and the *pre-existing condition* limitation will be credited as if you had been continually covered under the *Plan*.

Definitions:

For this provision only, the following terms are defined as stated.

Next of Kin - the nearest blood relative to the service member.

Parent - is your biological parent or someone who has acted as your parent in place of your biological parent when you were a *son* or *daughter*.

Serious health condition - is an *illness, injury*, impairment or physical or mental condition that involves:

- Inpatient care in a *hospital*, hospice, or residential medical facility; or
- Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or *surgery*, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

Serious illness or injury - is defined as an *illness* or *injury incurred* in the line of duty that may render the service member medically unfit to perform his or her military duties.

Son* or *Daughter - is your biological, child, adopted child, stepchild, foster child, a child placed in your legal custody or a child for which you are acting as the parent in place of the child's natural blood related parent. The child must be:

- Under the age of 18; or
- Over the age of 18, but incapable of self-care due to a mental or physical disability.

Spouse - is your husband or wife.

NOTE: For complete information regarding your rights under *FMLA*, contact your *participating employer*.

May I continue participation while I am absent under *USERRA*?
If you are absent from employment because you are in the *uniformed service*, you may elect to continue your coverage under this *Plan* for up to 24 months. If you elected to continue coverage under *USERRA* before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions in accordance with the options outlined above for a *participant* who goes on *FMLA leave*.

When does my participation end?
If you terminate employment with the *participating employer*, your participation in this *Plan* will terminate on the last day you are *actively at work* unless you elect to continue your participation in accordance with the guidelines provided in the "*COBRA* continuation coverage" section. Any *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses incurred* during the *plan year* prior to the date of termination will be reimbursed by the *Plan* in accordance with the guidelines in the section, "Benefits." Your participation in this *Plan* will also terminate if the *participating employer* decides to terminate this *Plan*, or if you voluntarily decide not to participate under the terms of this *Plan*.

If your participation in this *Plan* terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the *Plan* for the remainder of the *plan year* or continue your participation in accordance with the "*COBRA* continuation of coverage" section. If you do not make payments as required under *COBRA*, it will be assumed that you elected to revoke your participation in this *Plan*.

If your employment terminates, and you return to eligible employment with your *participating employer* OR within ninety (90) days, you may rejoin the *Plan* provided that you keep your original election for that *plan year* for the remainder of the *plan year,* as long as the termination was not for the purpose of altering the original election.

If you do not complete and file a *salary contribution agreement* during the *annual enrollment period*, your participation will end at the end of the *plan year*.

COBRA* continuation of coverage for contributions to a *qualified medical flexible spending account

If you are a *participant* in the *Plan*, you, your *spouse* or your *dependents* may be eligible for continued coverage under *COBRA* for contributions made to a *qualified medical flexible spending account*. *COBRA* may give you the right to continue your benefits under a *qualified medical flexible spending account* beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by you. Coverage will end in certain instances, including if you fail to make timely payment of premiums. Generally, *COBRA* applies to employers with 20 or more employees. You should check with your *participating employer* to see if *COBRA* applies to you.

When am I eligible for *COBRA*?

You may elect *COBRA* coverage if a *qualifying event* occurs and results in a loss of participation in the *Plan*, such as:

- The death of the *participant*.
- The termination of the *participant's* employment (other than by reason of the *participant's* gross misconduct) or reduction in the *participant's* hours of employment.
- The divorce or legal separation of the *participant* from his *spouse*.
- A *dependent* child ceases to be a *dependent* under the terms of the *Plan*.
- The *participant* becomes entitled to *Medicare* benefits.

In the event that the *COBRA* premium for the remainder of the *plan year* exceeds the maximum benefit still available under the *qualified medical flexible spending account* as of the date of the *qualifying event*, the *Plan Administrator* has the option to either not offer *COBRA* continuation coverage, or offer the coverage for the remainder of the *plan year*.

Who may elect *COBRA* coverage?

The following people are known as *qualified beneficiaries* and may elect *COBRA* coverage that will include the benefits to which they were entitled to under the *Plan* on the day before one of the above *qualifying events*:

- The *spouse* or any *dependent* child of the *participant* under the *Plan*.
- The *participant*, if the *qualifying event* is the termination of coverage due to termination of employment or reduction in hours.

If a *dependent* under the *Plan* who is also a *qualified beneficiary* has a newborn child, adopts a child, or a child is placed for adoption with that *dependent*, that child will be entitled to the same *COBRA* coverage period, but will not become a *qualified beneficiary* in his own right.

If you have a newborn child, adopt a child, or a child is placed for adoption with you, that child will become a *qualified beneficiary* in his right.

Who must be notified when a *qualifying event* occurs?
For *qualifying event*s such as divorce, legal separation or change in *dependent* status, you must inform the *Plan Administrator* of the event within 60 days of the event. For *qualifying events* such as death, termination or reduction in hours, entitlement to *Medicare*, bankruptcy or failure to return from leave under the *FMLA*, the *participating employer* has 30 days from the date of the *qualifying event*, or the date that you will lose coverage due to the *qualifying event,* in which to notify the *Plan Administrator*. The *Plan Administrator* has the obligation to furnish you, your *spouse* and your *dependents*, if they are eligible to receive benefits under this *Plan*, with separate, written options to continue coverage within 14 days of receiving notice of the *qualifying event*.

You must notify the *Plan Administrator* within 31 days of a child's birth, adoption, or placement for adoption in order to add the child to the continuation coverage.

What is the cost of *COBRA* coverage?
If you are eligible for and choose to continue coverage, you will be required to pay 102% of your normal contribution. This contribution will be on an after-tax basis.

How long may coverage be continued?
If you have experienced a *qualifying event* and have a positive balance in your *qualified medical flexible spending account* at the time of the event (taking into account all claims submitted before the date of the event), you may be eligible to continue participation in this *Plan* under *COBRA*. Your *COBRA* coverage period ends on the last day of the *plan year* in which the *qualifying event* occurs.

What is the effect of the Trade Act?
Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits that you may receive under *COBRA*. First, if you lose your job due to international trade agreements you may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Also, if you lose your job due to international trade agreements, you may be allowed an additional 60-day period to elect *COBRA* continuation coverage. If you elect continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

Qualified medical flexible spending expenses
If you elect to contribute to a *medical flexible spending account*, the *Plan* will reimburse you for *qualified medical flexible spending expenses* which are *incurred* by you, your *spouse*, or your *dependent* during the *plan year*.

Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount you elected under your *salary contribution agreement* for the *plan year* to contribute to your *qualified medical flexible spending account*. It is important to keep in mind that you cannot use amounts contributed to a *qualified dependent care flexible spending account* to pay *qualified medical flexible spending expenses.*

What are *qualified medical flexible spending expenses*?
Qualified medical flexible spending expenses are *health care expenses* which are excludable as income according to *Code* § 105(b). *Qualified medical flexible spending expenses* may not be otherwise reimbursable under the *benefit plan* or other plan or by any other entity, and they may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

What are examples of qualified and non-*qualified medical flexible spending expenses*?
The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of *qualified medical flexible spending expenses* will be in accordance with those expenses *incurred* for medical care, as defined in *Code* § 213(d) of the Internal Revenue Code as stated at the time the expense is *incurred*.

Examples of *qualified medical flexible spending expenses* include:

- Acupuncture
- Alcoholism treatment
- Allergy tests and shots
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical conditions
- Birth control pills
- Birth prevention surgery
- Braille materials (books and magazines)
- Chiropractic services
- Christian Science practitioner fees
- Co-payments
- Contact lenses and supplies

- Crutches
- Deductibles on your and your *spouse*'s group plan
- Dental services (not cosmetic)
- Dentures
- Eyeglasses, including examination fees
- Healing services
- Hearing aids and batteries
- Hospital costs not covered by a group health plan
- Insulin
- Laboratory fees
- Laetrile by prescription
- Mental health care and fees
- Effective January 1, 2011, Over-the-counter drugs and medicines with a *prescription* from a physician that are *health care expenses*
- Nurses' fees
- Obstetrical expenses
- Orthodontic services, if medically necessary
- Orthopedic shoes prescribed by a physician
- Osteopaths' fees
- Oxygen
- Physicians' fees not covered by medical plan
- Podiatrists' fees
- Prescription drugs
- Radial keratotomy
- Ramps required by medical conditions
- Rental of medical equipment

- Routine physical examinations
- Seeing eye dogs and their upkeep
- Smoking cessation programs, only if monitored by a licensed practitioner
- Special communications equipment for the deaf
- Therapeutic care for substance abuse (drug or alcohol)
- Weight loss programs prescribed by physicians for specific health problems
- Wheelchairs

Examples of non-*qualified medical flexible spending expenses* include:

- Condoms
- *Cosmetic surgery*, except those procedures necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- Funeral expenses
- Health insurance premiums
- Massage therapy
- Maternity clothes
- Nursing home expenses
- Weight loss programs prescribed by physicians for general health improvement
- Effective January 1, 2011, Over-the-counter drugs and medicines without a *prescription*

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Internal Revenue *Code* §§ 105(b) and 213(d) as stated at the time the expense is *incurred*.

Qualified dependent care flexible spending expenses

If you have elected to contribute to a *dependent care flexible spending account,* the *Plan* will reimburse you for *qualified dependent care flexible spending expenses* which are *incurred* by you during the *plan year*.

Reimbursement for *qualified dependent care flexible spending expenses* is limited to the annualized amount you elected under your *salary contribution agreement* to contribute to a *qualified dependent care flexible spending account* for the *plan year.* It is important to keep in mind that you cannot use amounts contributed to a *qualified medical flexible spending account* to pay *qualified dependent care flexible spending expenses.*

What are *qualified dependent care flexible spending expenses*?
Qualified dependent care flexible spending expenses are employment-related *dependent* care expenses eligible for reimbursement under the *Plan* as determined under *Code* §§ 129(e) (1) and 21(b). Such expenses include amounts paid for daycare and other household services and for the care of *qualifying individuals* enabling you to be gainfully employed.

What are examples of qualified and non-*qualified dependent care flexible spending expenses*?
The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of eligible expenses will be in accordance with *Code* §§ 21 and 129, as stated at the time the expense is *incurred*.

Examples of *qualified dependent care flexible spending expense*s include:

- Fees of a licensed *dependent care center* that cares for your *dependent* child.
- After-school care expenses.
- Wages of individuals who provide care inside or outside your home for your *dependent* child under age 13 or a *qualifying individual* over age 13 who is incapable of self-support.
- Federal and state employment taxes you pay for an individual you employ to provide *dependent* care.
- Day camps.
- Pre-school or nursery school tuition.

Examples of non-*qualified dependent care flexible spending expense*s include:

- Educational expenses for a child in first grade or above.
- Transportation, entertainment, food or clothing unless such items are incidental and cannot be separated from the cost of the care provided.
- Household expenses that are not attributable at least in part to the care of the *qualifying individual*.
- Expenses for a camp where a *qualifying individual* spends the night.

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with *Code* §§ 21 and 129, as stated at the time the expense is *incurred*.

Benefit costs
By electing to participate in the *premium only plan*, your portion of the *benefit costs* will be taken out of your salary and paid using pre-tax dollars.

Debit card feature
Qualified medical flexible spending expenses may be purchased directly from the merchant or provider of services through the use of a *debit card*. Similarly, *qualified dependent care flexible spending expenses* may be purchased directly from the provider of services through the use of a separate *debit card*. This is a very convenient way to access the benefits of the *Plan*. Here is how the *debit card* feature works:

When you enroll in the *Plan* each year, you must certify that the *debit card* will only be used for either *qualified medical flexible spending expenses*, as defined in *Code* § 213(d) listed above or *qualified dependent care flexible spending expenses*, as defined above. If you contribute to both a *qualified medical flexible spending account* and a *qualified dependent care flexible spending account*, you will receive a separate card for each account. You must also certify that you will not pay any expense with the *debit card* that has been reimbursed and that you will not seek reimbursement for the expense under any other plan covering health benefits or dependent care, respectively. The certification will be printed on your *debit card*, and by using the card, you will reaffirm the certification each time you use the *debit card*.

When you use the *debit card* at the point-of-sale, the merchant or provider of service is paid the full amount of either the *qualified medical flexible spending expense* or the *qualified dependent care flexible spending expense* (assuming there is sufficient coverage in your account), and your maximum available coverage remaining is reduced by that amount. Your use of the *debit card* is limited to the maximum dollar amount of coverage available in your *qualified medical flexible spending account* or your *qualified dependent care flexible spending account*.

Your *debit card* is ineffective except at those merchants and providers of service authorized by the *Plan*, so that the use of the card at other merchants or service providers will be rejected. The *Plan* limits the *debit card's* use to specified Merchant Codes relating to covered health care or dependent care. Thus, the *debit card's* use is limited to physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers of service or providers of dependent care service.

You must agree to acquire and retain sufficient documentation for any expense paid with the *debit card*, including invoices and receipts where appropriate. All charges to the *debit card* are treated as conditional pending confirmation of the eligibility of the charge through your documentation. Within thirty (30) days of using your *debit card*, you must submit an invoice or receipt from the merchant or provider of service, including the information required under either Sections "How do I file a claim for *qualified medical flexible spending expenses*" or "How do I file a claim for *qualified dependent care flexible spending expenses"* as applicable.

Substantiation of *qualified medical flexible spending expenses* will be satisfied without additional documentation when:

- The dollar amount of the transaction at a health care provider exactly equals the dollar amount of the copayment under the *benefit plan* for that service;
- The expense is a recurring expense that exactly matches a previously approved *qualified medical flexible spending expense* at this provider for the same time period;
- Verification is provided to the *Plan* through "real-time substantiation" that the expense is a *qualified medical flexible spending expense* by the provider of service, merchant or independent third party (e.g., Pharmacy Benefit Manager).

Substantiation of *qualified dependent care flexible spending expenses* will be satisfied without additional documentation when:

- The expense is a recurring expense that exactly matches a previously approved *qualified dependent care flexible spending expense* at this provider for the same time period; and
- Verification is provided to the *Plan* through "real-time substantiation" that the expense is a *qualified dependent care flexible spending expense* by the provider of service, merchant or independent third party.

You should verify that the *Plan Administrator* considers any expenses substantiated.

If the *Plan Administrator* finds that any claims have been paid that are not for *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses*, you are required to refund any amount so identified to the appropriate account. In addition, the *Plan* reserves the right to suspend your use of the *debit card* and/or credit the overpayment against other *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses*, that you may submit until the overpayment refund is satisfied. Amounts overpaid for *qualified medical flexible spending expenses* will not be credited against *qualified dependent care flexible spending expenses* and vice versa.

Your *debit card* will automatically be cancelled if your employment terminates or if your participation in the *plan* otherwise terminates.

Must I file a claim for benefits under the *premium only plan*?
No, it is not necessary to file a claim for benefits under a *premium only plan.* Amounts taken out of your pay pursuant to a *salary contribution agreement* will automatically be used to pay your *benefit costs.*

How do I file a claim for benefits under a *qualified medical flexible spending account* if it is not a self-substantiating debit charge?

You must submit a properly completed and documented claim to:

Flex Administrator
Insurance Management Services
P. O. Box 15688
Amarillo, Texas 79105
Fax No. 806-322-3142

It must include the following information:

- The name of the person or persons on whose behalf the expenses have been *incurred*.
- The nature of the expenses *incurred* (that is, a description of the services or supplies being claimed).
- The date the expenses were *incurred*.
- Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any *benefit plan*, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letter(s) from the *benefit plan*(s). Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved by the *Plan Administrator* certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are eligible for reimbursement under the *Plan*.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

How do I file a claim for benefits under a *qualified dependent care flexible spending account* if it is not a self-substantiating debit charge?

You must submit a properly completed and documented claim to:

Flex Administrator
Insurance Management Services
P. O. Box 15688
Amarillo, Texas 79105
Fax No. 806-322-3142

It must include the following information:

- A list of names of the eligible *qualifying individual* for whom the expenses were *incurred*, the ages of such *qualifying individual*, and the *qualifying individual's* relationship to you.
- If any of the services were performed outside of your home for a *qualifying individual* incapable of caring for him, a statement as to whether the *qualifying individual* regularly spends at least eight hours a day in the your home.
- If any of the services are performed for a *qualifying individual* who is physically or mentally incapable of caring for himself, a statement to that effect.
- A description of the nature and dates of performance of the qualifying services for which cost you wish to be reimbursed.
- A description of the relationship, if any, to you of the person or persons who performed the services.
- A statement indicating that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt *dependent care facility*) the taxpayer identification number of the provider of the services.
- If you are married, a statement as to whether you plan to file a separate federal income tax return from your *spouse*.
- If you are married, and your *spouse* is employed, a statement of your *spouse's* compensation.
- If you are married and your *spouse* is not employed, a statement that your *spouse* is incapacitated, or that your *spouse* is a *student*, and indicating the months of the year during which the *spouse* attends an educational institution on a full-time basis.
- A statement as to the amount, if any, of tax-exempt *dependent* care assistance benefits received from any other employer for you or your *spouse* during the *plan year*.
- Evidence of indebtedness or payment by you to the third party who performed the services.

- Written evidence, signed by an independent third party stating that the expenses have been *incurred*, the amount of such expenses, the date of services, and such other information as the *Plan Administrator* in its sole discretion may request.

- A statement as to where the services were performed.

- A statement indicating whether the services are necessary to enable you to be gainfully employed.

- A statement that the expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.

- A statement, signed by you and is such form as determined by the *Plan Administrator*, certifying that the expenses for which reimbursement is sought are expenses that you believe in good faith are eligible for reimbursement.

You must also attach a paid receipt from your day care provider or from the individual who provides the care. The social security number or the federal tax identification number of the provider **must** appear on the claim form or receipt. The individual who provides the care cannot be your *spouse* or a *dependent* under the age of 19.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

Is there a time limit for filing claims?
Claims for reimbursement under either a *qualified medical flexible spending account* or a *qualified dependent care flexible spending account* should be submitted within thirty (30) days following the date the expense was *incurred*. All claims for reimbursement must be submitted within ninety (90) days following the end of the *plan year,* or if earlier, on or before September 30th of the year you cease to participate in the *Plan*, or the claims will be denied.

Is there a minimum claim amount?
There is no minimum amount you may submit for a claim.

What if my *qualified medical flexible spending account* balance or my *qualified dependent care flexible spending account* balance is less than my claim?
Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the *qualified medical flexible spending account* for the *plan year* under a valid *salary contribution agreement*. Reimbursement for *qualified dependent care flexible spending expenses* is limited to the amount that you have elected to reduce your salary or wages to contribute to the *qualified dependent care flexible spending account* for the *plan year* under a valid *salary contribution agreement* for that *plan year*.

To the extent that it is not used to pay claims, the amount of contributions to your *qualified medical flexible spending account* will accumulate throughout the *plan year*. If you submit an eligible claim during the *plan year* in an amount that exceeds your current *qualified medical flexible spending account* balance, the *Plan* will reimburse your claim expense up to the annualized amount of contributions, less any amounts already used to pay claims. Your salary contribution election amount will continue to be taken for the remainder of the *plan year*.

To the extent that it is not used to pay claims, the amount of contributions to your *qualified dependent care flexible spending account* will also accumulate throughout the *plan year*. If you submit an eligible claim during the *plan year* in an amount that exceeds your current *qualified dependent care flexible spending account* balance, the *Plan* will reimburse your claim expense up to the total amount of contributions in your *qualified dependent care flexible spending account*, less any amounts already used to pay claims. As contribution amounts become available in your *qualified dependent care flexible spending account,* they may be used to reimburse any unpaid balance from a previously submitted *qualified dependent care flexible spending expense.* At no time during the *plan year* will the amount paid for claims exceed the amount of contributions made to the *qualified dependent care flexible spending account*.

In no instance can amounts contributed to a *qualified medical flexible spending account* be used to reimburse *qualified dependent care flexible spending expenses*, or vice versa.

What if I do not use all of the money in my *qualified medical flexible spending account* or my *qualified dependent care flexible spending account*?

You have ninety (90) days after the end of the *plan year* to file any *qualified medical flexible spending expenses* and *qualified dependent care flexible spending expenses incurred* for that year. If you fail to file for reimbursement within this time limit, or if you did not incur enough *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* to meet your annual salary contribution amount to each respective account, you forfeit any unused funds in your account.

May I withdraw any or all of the balance of *qualified medical flexible spending account* for expenses other than *qualified medical expenses?*

No. The only exception to this rule is for *qualified reservist distributions.*

FUNDING

How is a *qualified medical flexible spending account* funded?
Your *qualified medical flexible spending account* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement Qualified medical flexible spending expenses* will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed $2,500 for each *plan year.* The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected.

The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the "Benefits" section.

How is a *qualified dependent care flexible spending account* funded?
Qualified dependent care flexible spending expenses will be reimbursed to you to the extent of the amount you have elected to reduce your salary or wages for the *plan year* under a valid *salary contribution agreement,* not to exceed the amount in your account at the time reimbursement is requested.

Your salary or wage may be reduced in an amount you elected under the *salary contribution agreement*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *plan year*.

The *Plan Administrator* will establish an individual *qualified dependent care flexible spending account* for you and will credit to your account the amounts taken out of your pay for each pay period.

The *Plan* will reimburse you for *qualified dependent care flexible spending expenses* as described in the "Benefits" section.

How much can I elect to contribute to my *qualified dependent care flexible spending account*?
If you are not married you may contribute up to $5,000 to a *qualified dependent care flexible spending account*; however, in the event that your *earned income* is less than $5,000, you may contribute an amount not to exceed your *earned income* for the taxable year. If you begin participation in the middle of the *plan year* you may contribute up to $5,000 less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year*.

If you are married, you may contribute an amount up to the lesser of the *earned income* of you or your *spouse*, not to exceed $5,000. If you and your *spouse* file separate tax returns, you may elect to contribute an amount up to $2,500 to the *Plan*. If you begin participation in the middle of the *plan year* you may contribute up to $5,000, or $2,500 if you and your spouse file separately, less any amounts that you have contributed to any other *qualified dependent care flexible spending account* during the *plan year*.

If your *spouse* is a full-time *student,* for each month in which he is a full-time *student*, for the purpose of determining how much you can contribute under this plan, he will be considered to be gainfully employed, and to have *earned income* of not less than $250 per month if there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than $500 per month if there are two or more *qualifying individual*s with respect to the taxpayer for the taxable year.

If your spouse is a *qualifying individual*, for the purpose of determining how much you can contribute under this plan, he will be considered to be gainfully employed, and to have *earned income* of not less than $250 per month if there is one *qualifying individual* with respect to the taxpayer for the taxable year and not less than $500 per month if there are two or more *qualifying individual*s with respect to the taxpayer for the taxable year.

Minimum Election Amounts
There is no minimum amount you may elect to contribute to your *qualified medical flexible spending account*.

There is no minimum amount you may elect to contribute to your *qualified dependent care flexible spending account*.

How is a *premium only plan* funded?
The *premium only plan* is funded by your contributions under a *salary contribution agreement* with the *participating employer*. The contribution amounts paid under the *salary contribution agreement* will be adjusted automatically during a *plan year* to reflect changes in the *benefit cost*.

Order of funding
The total salary contribution amount for this *Plan* for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: the *premium only plan,* the *qualified medical flexible spending account,* then the *qualified dependent care flexible spending account.* The total salary contribution amount will be reduced by the amount it exceeds your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting
The *Plan Administrator* will maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of *qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* on behalf of each *participant*. All contributions will be held as part of the general assets of the *participating employer*. No trust fund will be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this *Plan*.

SALARY CONTRIBUTION AND DISCRIMINATION

Election period for salary contribution
In order to fund a *qualified medical flexible spending account, qualified dependent care flexible spending account,* or the *benefit costs* for a *premium only plan* for a *plan year*, you must complete and file with the *Plan Administrator* an appropriate *salary contribution agreement* election form as described in the section, "Eligibility for Participation." You should consider carefully the amount of salary contribution you elect for each account because you will forfeit any unused amount at the end of the *plan year.*

Termination, revocation, or amendment of salary contribution elections
Your *salary contribution agreement* election for a *plan year* will terminate at the end of the *plan year*. You must make an affirmative election for a new salary contribution for each *plan year*.

Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, "Eligibility for Participation," "May I make mid-year changes?".

Forfeiture of salary contribution amounts
If you fail to claim any amounts in the *qualified medical flexible spending account*, *qualified dependent care flexible spending account,* or *premium only plan* within the time limits specified in the section, "Benefits," "Is There a Time Limit for Filing Claims?," such amounts will be forfeited by you to the *Plan Sponsor*.

Reduction of salary contribution elections to prevent discrimination in favor of prohibited group(s)
The *Plan* is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits and is intended to comply in this respect with the requirements of the *Code*. If, in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *plan year* would result in such discrimination, then the *Plan Administrator* shall select and exclude from coverage under the *Plan* such highly compensated individuals who are *participants*, and/or reduce contributions under the *Plan* by highly compensated individuals who are *participants*, to the extent necessary to assure that, in the judgment of the *Plan Administrator*, the *Plan* does not discriminate.

The *Plan Administrator* will have the full authority to reduce the salary contribution elections of *participants* who are members of the prohibited group(s) under *Code* §§ 105(h) or 125, to the extent necessary to prevent the *Plan* from discriminating in favor of such prohibited group(s).

Determination of noncompliance
In the event that a determination is made that all or any part of the contributions to the *Plan* do not qualify as non-taxable contributions to a "cafeteria plan" under *Code* § 125, the affected contributions made by any *participant* will be treated as salary, and any unpaid balance in the *qualified medical flexible spending expense account,* the *qualified dependent cared flexible spending account* and the *premium only plan* will be returned to the *participant*. The *participant* must pay:

- Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed;

- The *participant's* share (as determined in good faith by the *participating employer*) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the *participating employer* had such amounts been treated as salary and not as *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses,* or *benefit costs*; and

- An amount (as determined in good faith by the *participating employer*) equal to the portion of any applicable penalties and interest payable by the *participating employer* as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the *participant*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?
The *Plan* is administered by the *Plan Administrator*. The *Plan Administrator* has retained the services of the *third party administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are not *qualified medical flexible spending expenses, qualified dependent care flexible spending expenses,* or *benefit costs*), to decide disputes which may arise relative to a *participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a *third party administrator* to pay claims;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan*'s administration.

May changes be made to the *Plan*?
The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the *Plan* is terminated, the rights of *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

Additional operating rules
A *participant's* salary contribution amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary contribution amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

Salary contribution amounts under this *Plan* shall not reduce salary or wage for purposes of any other employer sponsored employee benefit programs unless the provisions of those programs otherwise provide.

MISCELLANEOUS INFORMATION

Will the *Plan* release my information to anyone?
For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?
Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that it has determined that the *Plan Administrator* has mistakenly reimbursed an expense which did not qualify under the terms of the *Plan*, the *Plan Administrator* may adjust your pay and appropriately credit the *qualified medical flexible spending account, qualified dependent care flexible spending account* or *premium only plan*.

Will the *Plan* conform with applicable laws?
This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*

When must legal actions be filed?
Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the *benefit costs, qualified medical flexible spending expenses* or *qualified dependent care flexible spending expenses* are *incurred* or are alleged to have been *incurred*. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claims Review Procedures."

What constitutes a fraudulent claim?
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this *Plan*:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your *spouse* or your *dependent* according to the *Plan*;
- Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?
The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Participants* are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this *summary plan description* applies to *participants*.

How may a *Plan* provision be waived?
No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this *summary plan description* a contract between the employer and *participants*?
This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *participating employer* and any *participant* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *participating employer* or to interfere with the right of the *participating employer* to discharge any *employee* at any time.

May I appoint an authorized representative?
A *participant* is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator.* In the event a *participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *participant,* unless the *participant* directs the *Plan Administrator,* in writing, to the contrary.

How will the *Plan* pay benefits?
All benefits under this *Plan* are payable, in U.S. Dollars, to the *participant* or, if appropriate, the *alternate recipient*. In the event of the death or incapacity of a *participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his estate, the *Plan Administrator* may, in its sole discretion, make any and all payments due under the *plan* to the individual or institution which, in the opinion of the *Plan Administrator,* is or was providing the care and support of such *participant*.

What if my claim is for non-U.S. Providers?
Qualified medical flexible spending expenses and *qualified dependent care flexible spending expenses* for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a *"non-U.S. provider"*) may be reimbursed under the following conditions:

- The *participant* is responsible for making all payments to *non-U.S. providers,* and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all requirements under *Code* § 105; and
- Claims for benefits must be submitted to the *Plan* in English.

How will the *Plan* recover payments made in error?
Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* on whose behalf such payment was made.

A *participant, spouse*, *dependent,* provider, another benefit plan, insurer, or any other person or entity who receives a payment made in error under the terms of the *Plan,* shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum or other arrangement, as agreed.

Participants accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with the requirements of this *Plan*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* shall be entitled to recover its litigation costs and actual attorneys' fees *incurred*.

How will the *Plan* handle *medical child support orders*?
The *Plan Administrator* shall adhere to the terms of any *medical child support order* that satisfies the requirements of this section. The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a *medical child support order* that is a *qualified medical support order* if such an individual is not already covered by the *Plan* as a *dependent*.

The *Plan Administrator* shall promptly notify the *participant* and each *alternate recipient* of:

- The receipt of a *medical child support order* by the *Plan*; and
- The *Plan's* procedures for determining the qualified status of *medical child support orders*.

Within a reasonable period after receipt of a *medical child support order*, the *Plan Administrator* shall determine whether such order is a *qualified medical child support order* and shall notify the *participant* and each *alternate recipient* of such determination. If the *participant* or any affected *alternate recipient* disagrees with the determinations of the *Plan Administrator*, the disagreeing party shall be treated as a claimant and the claims procedure provided in the section, "Claims Review Procedures," of the *Plan* shall be followed. The *Plan Administrator* may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the *Plan*.

Upon receiving a *national medical support notice*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the *Plan*, and if so:
  - Whether the child is covered under the *Plan*; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *medical child support order* or a *national medical support notice*; and
- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

Payments made under this *Plan* pursuant to a *medical child support order* described in this section in reimbursement for expenses paid by the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian shall be made to the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian.

Will the *Plan* provide a statement of benefits?
On or before January 31 of each year, the *Plan Administrator* will furnish, upon request, a written statement showing amounts paid or the expenses *incurred* by the *Plan Sponsor* in providing reimbursement under the *Plan* for *qualified dependent care flexible spending expenses, qualified medical flexible spending expenses,* and *benefit costs* for the prior *plan year*.

CLAIMS REVIEW PROCEDURE

Upon receipt of complete information, the claim will be deemed to be filed with the *Plan*. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by *the Third Party Administrator* within forty-five (45) days from receipt by the *participant* of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of claim decisions

The *Plan Administrator* shall notify you, in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

- If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the *Plan Administrator.*

Extensions. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an adverse benefit determination

The *Plan Administrator* shall provide you with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *summary plan description* upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *participant,* free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, or a statement that such explanation will be provided to you, free of charge, upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and fair review of all claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- *Participants* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and ninety (90) days to appeal a second adverse benefit determination;

- *Participants* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the *participant* relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the Plan did not rely upon their advice; and

- That a *participant* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *participant's* claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *participant's* medical circumstances.

FIRST APPEAL LEVEL

Requirements for first appeal

You must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

Flex Administrator
Insurance Management Services
P. O. Box 15688
Amarillo, Texas 79105
Fax No. 806-322-3142

It shall be your responsibility of to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The *participant's* name;
- The *participant's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *participant* will lose the right to raise factual arguments and theories which support this claim if the *participant* fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *participant* has which indicates that the *participant* is entitled to benefits under the *Plan*.

If the *participant* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of notification of benefit determination on first appeal

- The *Plan Administrator* shall notify the *participant* of the *Plan's* benefit determination on review within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The *Plan Administrator* shall provide a *participant* with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the *summary plan description* on which the denial is based;

- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you*t* upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, will be provided free of charge upon request;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures; and,
- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, you have ninety (90) days to file a second appeal of the denial of benefits. You again are entitled to a "full and fair review" of any denial made at the first appeal, which means you have the same rights during the second appeal as you had during the first appeal. As with the first appeal, your second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

- The *Plan Administrator* shall notify you of the *Plan's* benefit determination on review within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the *Plan's* response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is needed; and
- A description of the *Plan's* review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, the *participant* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one hundred eighty (180) days after the *Plan's* claim review procedures have been exhausted.**

***HIPAA* PRIVACY PRACTICES**

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of s*ummary health information* to the *Plan Sponsor*
In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (the ***"****privacy standards****"***), the *Plan* may disclose *summary health information* to the *Plan Sponsor,* if the *Plan Sponsor* requests the *summary health information* for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan;* or

- Modifying, amending or terminating the *Plan*.

"*Summary health information****"*** may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan,* but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of protected health information *("PHI")* to the *Plan Sponsor* for *plan administration* purposes
In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan* documents or as *required by law* (as defined in the *privacy standards*);

- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;

- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor,* except pursuant to an authorization which meets the requirements of the *privacy standards;*

- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;

- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);

- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services *(****"****HHS****"****),* or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);

- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the *Plan Sponsor,* shall be given access to the *PHI* to be disclosed:

    Director of Employee Benefits
    Human Resources Director
    Plan Auditor
    Chief Financial Officer
    Any staff designated by one of the above positions

  - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.

  - In the event any of the individuals described in above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI,* the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" functions shall have the meaning ascribed to it in 45 CFR § 164.504(a),

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and

- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of certain enrollment information to the *Plan Sponsor*
Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor.*

Other disclosures and uses of *PHI*
With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards.*

HIPAA **SECURITY PRACTICES**

Disclosure of electronic protected health information ("*Electronic PHI*") to the Plan Sponsor for *plan administration* functions

In accordance with *HIPAA's* Security Standards for the Protection of *Electronic PHI* (the "*Security Standards"),* and to enable the *Plan Sponsor* to receive and use *Electronic PHI* for *plan administration* functions, the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the *Electronic PHI* that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides *Electronic PHI* created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the *Electronic PHI*; and
- Report to the *Plan* any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the *Security Standards*.