

SUMMARY PLAN DESCRIPTION

CAFETERIA PLAN

INTRODUCTION

Your Employer is pleased to sponsor an employee benefit program known as a “cafeteria plan” or a “flexible benefits plan” (the “Plan”) for its employees. It is so-called, because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. Your Employer provides you with the opportunity to use pre-tax dollars to pay for benefits by entering into a salary reduction arrangement instead of using a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your salary reduction.

This document describes the basic features of your Plan, how it operates, and how you can get the maximum advantage from it. The description is only a summary of the key parts of the Plan and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between the official plan documents and this description, the plan documents will apply.

Employer Information.

Employer: Community Action Partnership of Mid-Nebraska

Address: P.O. Box 2288, Kearney, NE 68848-2288

Telephone: 308-865-5675

Employer ID #: 47-6039628

Entry Date(s): The first day of the month coincident with or next following the day that the Employee becomes eligible to participate in the plan.

Plan Information.

Initial Effective Date: 1/1/1990

Amendment & Restatement Date: JANUARY 1, 2011

Plan Year: January 1st to December 31st

Plan Name: Community Action Partnership of Mid-Nebraska Cafeteria Plan

Plan Number: 50 _____

Entry Date(s): The first day of the month coincident with or next following the day that the Employee becomes eligible to participate in the Plan.

Eligible Benefits. The Employer elects to provide the benefits elected in this section under this Plan. Only the benefits elected in this section are provided, notwithstanding any other provision of the Plan to the contrary. *(Mark benefits to be provided.)*

Premium Conversion Plan with respect to the following plans:

Group Health Plan

Group Dental Plan

Group Vision Plan

Long Term Disability Plan *(Note: If premiums are paid on a pretax basis, the benefits provided under the Long Term Disability Plan are subject to income tax.)*

Short Term Disability Plan *(Note: If premiums are paid on a pretax basis, the benefits provided under the Short Term Disability Plan are subject to income tax.)*

Accidental Death and Dismemberment Plan

Group Term Life Insurance Plan *(to the extent of the first \$50,000 of coverage)*

Premiums for COBRA continuation coverage under the Group Health Plan

Medical Reimbursement Plan - The annual limit on amounts to be allocated to this plan is \$ 2,500. *(Effective January 1, 2013, the Code limits the maximum benefit available under the Medical Reimbursement Plan attributable to salary reduction contributions through the Cafeteria Plan to \$2,500 for any taxable year, plus any cost-of-living adjustment provided by Code Section 125(i) or applicable Treasury Regulations for taxable years beginning after December 31, 2013.)*

Note: The entire amount of the Medical Reimbursement Account is available for reimbursement of expenses from the first day of coverage, even though salary reductions occur throughout the Plan Year.

General Purpose *(reimburses all qualified medical expenses allowed under the Code)*

Limited Purpose *(only reimburses qualified medical expenses that are dental, vision, and preventative care expenses; allows employees to also contribute to Health Savings Accounts)*

If the Employer elects to sponsor both a General Purpose Medical Reimbursement Plan and a Limited Purpose Medical Reimbursement Plan, it should execute two Medical Reimbursement Plan documents and designate which document is the plan document for each plan.

- Dependent Care Assistance Plan
- Health and Accident Insurance Premium Reimbursement Plan
- Health Savings Accounts

Grace Period. Notwithstanding anything in this Summary Plan Description to the contrary, for Plan Years beginning on or after _____, _____ the Employer elects to allow Cafeteria Plan Participants to seek reimbursement of unused amounts remaining in their Medical Reimbursement Accounts and/or Dependent Care Reimbursement Accounts at the end of the Plan Year in accordance with the terms of the Medical Reimbursement Plan and Dependent Care Assistance Plan if elected below:

- The Employer elects to allow a Grace Period for the Medical Reimbursement Plan.
- The Employer elects to allow a Grace Period for the Dependent Care Assistance Plan.
- The Employer does not allow a Grace Period for the Medical Reimbursement Plan and the Dependent Care Assistance Plan.

Eligibility Requirements. If elected below, the definition of “Employee” and “Entry Date” are modified as follows:

“Employee” Only those Employees meeting the following requirements are eligible to participate in this Plan: Eligible at 24 (60% FTE) hours per week.

Entry Date” Eligible Employees participate on the following date: First day of the month following date of hire.

Employer Contributions. The only contributions to be made to this Plan are Salary Reduction Contributions unless the Employer elects below:

- N/A The Employer will make contributions in addition to Salary Reduction Contributions in the manner and amount described as follows:

Plan Administrator. The Employer is the Plan Administrator unless the Employer identifies a Plan Administrator below. *(Note: First Concord Group, LLC is not the Plan Administrator, but a claims administrator engaged to assist the Plan Administrator in fulfilling its duties under the Plan.)*

Plan Administrator: Community Action Partnership of Mid-Nebraska

EMPLOYER

Address: P.O. Box 2288
Kearney, NE 68848-2288
Telephone: 308-865-5675

Claims Administrator.

First Concord Group, LLC
5651 S. 59th St., Suite C
P.O. Box 67220
Lincoln, NE 68506
Telephone: 402-423-4454
Fax: 402-423-4549

GENERAL QUESTIONS AND ANSWERS ABOUT YOUR CAFETERIA PLAN

What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use a portion of their pay to choose (and pay for) one or more of the benefits offered through the Plan on a tax-favorable basis.

Who can participate in the Plan?

Any Employee who meets the eligibility conditions set out in the Introduction.

How do I become a Participant?

You become a Participant by signing a Benefits Enrollment Form on which you elect one or more of the benefits available under the Plan, as well as agreeing to a salary reduction to pay for the benefits you elect. You will be provided a Benefits Enrollment Form when you first become eligible to participate. Prior to the beginning of each Plan Year, you will be furnished a new Benefits Enrollment Form and be given the opportunity to confirm or change the choices you made for the previous 12-month period for the coming 12 months beginning on the first day of the next month. If you fail to return any Benefits Enrollment Form, you will be deemed to have elected to receive your entire pay in cash.

Can I change my election during the Plan Year?

Generally, you cannot change your election whether or not to participate in the Plan, or vary the benefits you have selected, during the Plan Year, although your election will terminate if you are no longer working for your Employer.

There are some important exceptions to this general rule. You may change or revoke your previous election at any time during the Plan Year with respect to insurance-type benefits requiring a premium payment if one or more of the following events or circumstances occur:

- (a) your marriage, divorce, legal separation, or annulment;
- (b) the death of the your spouse or a dependent;
- (c) your birth, adoption, or placement for adoption of a child, as defined by the Internal Revenue Code;
- (d) the termination of employment (or commencement of employment) of you, your spouse, or your dependent;
- (e) the switching from part-time to full-time employment status, or from full-time to part-time status by you, your spouse, or your dependent;
- (f) the taking of an unpaid leave of absence by you, your spouse, or your dependent;

- (g) a change in the place of residence of you, your spouse, or your dependent;
- (h) a change in the work site of you, your spouse, or your dependent;
- (i) any other event that changes the employment status of you, your spouse, or your dependent, if the eligibility conditions for the cafeteria plan or other employee benefit plan of your employer or the employer of your spouse or dependent depend upon employment status and there is a change in that employment status with the consequence that one or more of you becomes or ceases to be eligible under the plan;
- (j) an event that causes your dependent to satisfy or fail to satisfy the coverage requirements, including age, student status, or other similar requirement of a benefit plan;
- (k) a change by your spouse or dependent under his or her employer's cafeteria or other benefit plan, allowing you to change your election on account of and corresponding with the change made by your spouse or dependent provided that (1) the plan of your spouse's or dependent's employer permits its participants to make an election change that is permitted under the law, or (2) the period of coverage under your plan with your Employer is different from the period of coverage under the plan of your spouse's or dependent's employer;
- (l) if coverage under a benefit plan offered under the Plan is significantly curtailed resulting in a complete loss of coverage during a period of coverage, you may revoke your election and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package providing similar coverage, or if no similar benefit package option is available under the benefit plan, revoke your election for coverage under the Plan. A loss of coverage includes a substantial decrease in the medical care providers available under the option of health coverage (such as a major hospital ceasing to be a member of a preferred provider network), a reduction in the benefits for a specific type of medical condition or the treatment with respect to which you or your spouse or dependent is currently in a course of treatment, or any other similar fundamental loss of coverage. If coverage under a benefit plan of your Employer is significantly curtailed but without resulting in a complete loss of coverage during a period of coverage, you may revoke your election but must, in lieu thereof, elect to receive coverage on a prospective basis under another benefit package option under the benefit plan providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to employees under the plan so as to constitute reduced coverage to employees generally;
- (m) your Employer adds a new benefit package option or other coverage option or eliminates an existing benefit package option or other coverage option, allowing you to elect the newly added option or elect another option if an option has been eliminated and make corresponding election changes with respect to other benefit package options under the benefit plan which provide similar coverage;
- (n) If there is a significant increase or decrease in the cost of a benefit package option offered by your Employer during a period of coverage, you may revoke your election and, in lieu thereof, receive on a prospective basis, coverage under another benefit package option under the

Plan which provides similar coverage. If there is a significant increase in the cost of a benefit package option under a benefit plan and no other benefit package option under the plan provides similar coverage, you may revoke your election for coverage under the Plan. If there is a significant decrease in the cost of a benefit package option offered by your Employer during a period of coverage, you may elect to commence coverage in the Plan and elect the benefit package option that has significantly decreased in cost if you were not previously participating in the Plan;

(o) you are a party to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your child or foster child, allowing your Employer to automatically change your election to provide coverage for the child if the judgment, decree, or order requires coverage for the child under the Plan, or allowing you to make an election change to cancel coverage for the child if the judgment, decree, or order requires your former spouse or other individual to provide coverage, upon demonstration to your Employer that the coverage is actually being provided;

(p) you, your spouse, or your dependent becomes or ceases to be enrolled under Medicare or Medicaid, other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines, so that you may make an election change to cancel or elect prospective coverage for yourself, your spouse, or your dependent, as applicable; or

(q) if during a period of coverage, you, your spouse, or your dependent loses coverage under any group health plan sponsored by a governmental or educational institution, including any state's children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian tribal government (as defined in Internal Revenue Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a Foreign government group health plan, you may change your election to elect coverage under a group health plan of your Employer for you, your spouse, or your dependent.

Additionally, if you, your spouse, or dependent becomes eligible for continuation coverage under a plan of your Employer as provided in Internal Revenue Code ("Code") Section 4980B or any similar state law, you may elect to increase payments under this Plan in order to pay for the continuation coverage or make such election change as permitted by the Code. You will be notified of the terms and conditions of any such continuation coverage if affected.

You may revoke an election for health plan coverage during a period of coverage and make a new election that corresponds with the special election rights provided in Code Section 9801(f), whether or not the change in election is one which would ordinarily permit an election change. These rights involve the right to enroll new dependents or existing dependents who lose coverage or employer contributions to coverage under the health plan of another employer.

If an event occurs, you must inform your Employer of your new election within 30 days of the occurrence of such event which allows you to change your election. Failure to do so within the 30-day period will result in the changes in your election being applicable only to months during which, or after, you have notified the Plan Administrator.

You may revoke any election you made for the period during which you are absent from work for a family medical leave covered by the federal Family and Medical Leave Act (“FMLA”). You may reinstate your election of group medical benefits and coverage under any Medical Reimbursement Plan when you return from the FMLA leave. However, you may not reinstate a revoked election as to any non-health insurance benefits until the next regular election period.

Your Employer may modify your election(s) downward during the Plan Year if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

If your Employer offers a Dependent Care Assistance Plan, Medical Reimbursement Plan, or Health and Accident Insurance Premium Reimbursement Plan as indicated in the Introduction section under “Available Benefits,” the rules applicable to election changes for those benefits will be explained under the summary of those benefits, as applicable, later in this document.

Are there any other limits on my ability to change my election?

Yes. If an event occurs allowing you to change your election, your change must be on account of and consistent with the event. Your election change is consistent with the event only if (a) the event results in you, your spouse or your dependent gaining or losing eligibility for coverage under either a cafeteria plan or other benefit plan of an employer (yours or his or hers), and (b) your election change corresponds with that gain or loss of coverage. An event results in an individual’s gaining or losing eligibility for coverage under a plan only if the individual becomes eligible or ineligible to participate in the plan or a particular benefit option under a plan. The following examples illustrate this consistency requirement:

Example 1. You and your spouse divorce. As a result of the divorce, the court enters an order requiring your spouse to provide medical and dental coverage for your dependents. Two events have occurred so you may change your election. The new election would satisfy the consistency rules if your new election eliminated coverage for your spouse, due to the divorce, and your dependents, due to the court order. In no event could you revoke coverage for yourself in this situation.

Example 2. You have two school age children and a child in college. Your college age child graduates and fails to satisfy the coverage rules under a benefit plan offered under this Plan, because he is no longer a defined dependent. You may revoke an election for health and/or dental coverage and make a new election, covering only the two school age children. In no event could you eliminate coverage for the two school age children or yourself based on this event.

Example 3. Your spouse dies. You may revoke your election under the Plan for health and/or dental coverage for your spouse. If you had any dependents covered under the Plan, you would not be able to change your election with respect to your dependents (or yourself) based on this event.

What are the insurance-type benefits available under the Cafeteria Plan?

If you elect coverage under an insurance-type benefit plan of your Employer which would otherwise require you to pay all or a portion of the premiums for that coverage, the Cafeteria Plan allows you to pay for that coverage on a pre-tax basis, instead of deducting the amounts from your pay on an after-tax basis. Your election of the coverage which would otherwise require a contribution from you will instead constitute your election to have your pay reduced and to have your Employer pay for the coverage with the amount of your pay reduction. The reduction in your pay is only for purposes of this Plan and does not affect other compensation-based plans or policies, such as any 401(k) or profit-sharing plan. The specific insurance-type benefits offered by your Employer are listed in the Introduction.

How does the Cafeteria Plan work for insurance-type benefits?

When you complete the Benefits Enrollment Form, you specify which insurance-type benefits you will pay for on a pre-tax basis. Your Employer simply pays for the insurance coverage that you elect with the amount of the reduction in your pay that is required.

Who holds the funds I have set aside under the Plan for insurance-type benefits?

Insurance premiums will be forwarded to the respective insurance companies as the premiums become payable, normally monthly.

Will my account earn any interest?

No interest or other earnings will be credited to your account at any time.

Can I stay in the Plan if I am absent on a family medical leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act ("FMLA") for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the group health insurance coverage you have under the Plan during your absence. You must pay the premiums for the coverage during your absence using one of the three following methods as agreed to between you and your Employer.

Prepayment. Under the prepayment option, you may (at your option), prior to taking a leave of absence, increase your salary reduction election in an amount sufficient to cover the premiums that will come due during the FMLA leave. If your leave spans two Plan Years, you may only prepay your premiums for the remainder of the Plan Year in which your leave begins.

Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your pay while you are gone, the premiums will be paid with pre-tax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you will have to reimburse your Employer at regular intervals from your after-tax funds for the premiums that come due during the leave. If you fail to make any such after-tax payment to your Employer, the Employer may discontinue your insurance coverage. If you fail to make any such after-tax payment to

your Employer and your Employer chooses to continue your insurance coverage, your Employer is entitled to recoup those payments from you after you return to work from your leave.

Catch-up. Under the catch-up option, your Employer will pay your share of premiums while you are on leave. You will re-pay your Employer for your share of premiums when you return from your leave in a manner agreed to between you and your Employer.

What if I am absent from work for duty in the uniformed services?

Your right to continued participation in a group health plan during leaves of absence for uniformed service is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are returning to your employment from uniformed service, you may be entitled to reinstate your rights under the plan upon reemployment pursuant to USERRA. More information about coverage under USERRA is available from your Plan Administrator.

What happens to my insurance-type benefits if I terminate my employment during the Plan Year?

If your employment with your Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. Your coverage under any insurance plans will end in accordance with the terms of such plans.

What will happen to my previous election if I resume employment with my Employer?

If you are reemployed by your Employer within the Plan Year in which your termination occurred you may elect to participate in the Plan under the terms of your Benefits Enrollment Form in force prior to your termination. You may thereafter change your election during an annual election period or if an event occurs permitting you to change your election earlier.

Will I have to pay any administrative costs under the Plan?

No. Your Employer bears the entire cost of administering the Plan.

How long will the Plan remain in effect?

Although your employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan should not be currently taxable to you under present law,

provided that you comply with the terms of the Plan. However, your Employer cannot guarantee the tax treatment to any given participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

What happens if my claim for benefits under an insurance plan is denied?

Any claims for insurance-type benefits are administered under the terms of the insurance plans and will not be handled under the Cafeteria Plan.

DEPENDENT CARE ASSISTANCE PLAN QUESTIONS AND ANSWERS

A major feature of your Employer's Cafeteria Plan is your opportunity to elect to receive income-tax-free reimbursement for some or all of your work-related dependent care expenses under the Employer's Dependent Care Assistance Plan. Under this Plan, you provide a source of pre-tax funds to reimburse you for your eligible expenses by entering into a salary reduction arrangement with your Employer in lieu of receiving a corresponding amount of your regular pay after-taxes. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your salary reduction.

Who can participate in the Dependent Care Assistance Plan?

Each person who is eligible to participate in the Employer's Cafeteria Plan described above.

How do I become a Participant?

You participate in the Plan by electing Dependent Care Assistance Plan benefits on your Benefits Enrollment Form and executing a salary reduction agreement. If you fail to execute any Benefits Enrollment Form for a Plan Year, you will be deemed to have elected to contribute \$0 to the Plan for that Plan Year.

How does the Dependent Care Assistance Plan work?

If you elect to participate in the Dependent Care Assistance Plan, your Dependent Care Assistance Plan Account under the Plan will be credited with that portion of your gross income you have elected to forego through salary reduction to the Plan. That portion of your income which you apply to the Dependent Care Assistance Plan will be credited to your Account as of each pay period. For example, suppose you will incur \$2,600 of dependent care expenses during the plan year. Assuming you are paid every two weeks, the cost of the above benefits per paycheck would be \$100. Your Dependent Care Assistance Plan account would be credited with a tax-free total of \$2,600, spread equally over 26 paychecks. The amount that you have set aside will accumulate until you submit a documented claim for reimbursement of eligible expenses.

What is my "Dependent Care Assistance Plan Account?"

If you elect benefits under this Plan, a Dependent Care Assistance Plan Account ("Account") will be set up in your name to keep a record of the amounts withheld pre-tax from your pay, to which you are entitled under the terms of the Plan.

What are the maximum Dependent Care Assistance Plan benefits I may elect?

You may elect up to \$5,000 per Plan Year if you--

- (a) are married and file a joint return;

(b) are married, but you furnish more than one-half the cost of maintaining those dependents from whom you are eligible to receive tax-free reimbursements under the Dependent Care Assistance Plan, your spouse maintains a separate residence for the last six months of the calendar year, and you file a separate tax return; or

(c) are single or a head of household for tax purposes.

If you are married and reside with your spouse but file a separate federal income tax return, the maximum Dependent Care Assistance Plan benefit you may elect is \$2,500.

Who is an “eligible dependent” for whom I can claim a reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of:

(a) your child (or descendent of your child) under the age of 13 who has the same residence as you for more than half of the calendar year;

(b) your disabled spouse who is mentally or physically unable to care for himself or herself and who has the same principal residence as you for more than half the calendar year; or

(c) your disabled child or other qualified relative who: (1) is mentally or physically incapable of self-care; (2) receives more than one-half of his or her support from you; (3) does not have gross income exceeding specified IRS requirements (\$3,650 for 2010); and (4) has the same principal residence as you for more than one-half the calendar year.

For purposes of determining who is your dependent under the Dependent Care Assistance Plan, in the case of divorced parents, a dependent who is a child shall be treated as a dependent of the custodial parent and shall not be treated as a dependent with respect to the non-custodial parent.

How do I receive my benefits under the Plan?

If you have elected to participate in this Plan, you will have to take certain steps to be reimbursed for your “eligible dependent care expenses.” When you incur an expense that is eligible for payment, you may submit a claim to the Plan Administrator on a form that will be supplied to you. If you have enough funds in your Dependent Care Assistance Plan Account, you will be reimbursed for your eligible expenses. If your claim is for an amount that is more than your current Account balance, the excess part of the claim will be carried over into following months, to be automatically paid to you as your balance becomes adequate. Remember, though, that you cannot be reimbursed for any total expenses above your annual election amount. You may not be reimbursed for any expenses that arise before your Benefits Enrollment Form becomes effective. In addition, subject to any right to make a claim under any Grace Period elected by your Employer, you will not be reimbursed for any expense incurred after the close of the Plan Year. Please note that you must have actually paid an amount due for eligible dependent care expenses in order to be reimbursed for it.

When do I submit my claims?

You may submit claims for eligible dependent care expenses at any time during the Plan Year. In addition, you will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement of eligible expenses incurred during the previous Plan Year. If your employment with your Employer is terminated, you have 90 days following the last day of your employment to submit claims. You will be notified in writing if any claim is denied.

What is the “Grace Period” and how do I make a claim for reimbursement of Dependent Care Expenses incurred during the Grace Period?

Your Employer may elect to allow you to be reimbursed under the Dependent Care Assistance Plan (DCAP) from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a Grace Period following the end of the Plan Year. Any available Grace Period will begin on the first day of the new Plan Year and will end on the 15th day of the third month of the following Plan Year. Any unused amounts remaining in your DCAP Account at the end of the Grace Period are forfeited.

In order to take advantage of any Grace Period offered by your Employer, you must be a Participant in the Plan with DCAP coverage that is in effect on the last day of the Plan Year to which the Grace Period relates.

To the extent your Employer provides a Grace Period, the following additional rules apply to Dependent Care Expenses that are incurred during the Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Dependent Care Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume the Plan Year runs from January 1 to December 31. Assume further that \$200 remains in your DCAP Account at the end of the 2010 Plan Year and that you have also elected \$2400 of DCAP coverage for 2011. If you submit a \$500 Dependent Care Expense that was incurred on January 15, 2011, \$200 of your claim will be paid out of the unused amounts remaining in your DCAP Account from the 2010 Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the 2011 Plan Year. Claims will be paid in the order in which they are approved.

- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$500 Grace Period expense, you discover \$200 of the 2010 Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2010 expenses. The Plan will not reprocess the \$500 Grace Period expense so as to pay it entirely from your 2011 DCAP amounts. For this reason, if you have DCAP coverage for both the prior and current years you may want to

wait to submit Dependent Care Expenses you incur during the Grace Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

- Expenses incurred during a Plan Year or its Grace Period must be submitted by the end of the fourth month following the close of the Plan Year in order to be considered for reimbursement from amounts remaining at the end of that Plan Year. Unused amounts remaining in a Participant's DCAP Account at the end of a Plan Year that are not applied to pay expenses submitted on or before this deadline will be forfeited.

What is an “eligible dependent care expense” for which I can seek reimbursement?

Please review the general list below of eligible dependent care expenses in determining what is an “eligible expense.” You are also encouraged to consult your personal tax advisor or IRS Publication 17, Code sections 129(e) and 21(b)(2), or IRS Publication 503 for further guidance as to what is or is not an eligible expense if you have any doubts.

You Should Claim

Only amounts paid or payable to someone other than your spouse, your child who is under age 19, or a person for whom you can receive a deduction for tax purposes

Child or dependent care expenses that allow you to work or look for work

Expenses of qualified daycare centers

Household services, such as services of a housekeeper, maid or cook incidental to care of a qualifying dependent

Only amounts paid that do not exceed your annual salary reduction

Cost of in-home baby sitters, pre-school tuition and summer day camps

Cost of services provided outside the home if the dependent spends at least 8 hours per day in the home

You Should Not Claim

Any items for which you intend to claim as a credit for federal tax purposes

Educational expenses for any child in or beyond the 1st grade

Amounts in excess of your annual salary reduction

Cost of food, clothing, shelter, insurance, medical treatment or vacations of a qualifying individual

Costs for services outside your household at a camp where a qualifying individual stays overnight

May I withdraw cash from my Dependent Care Assistance Plan account?

No. Your account balance may be used only to provide reimbursement for eligible expenses.

Will I be taxed on the Dependent Care Assistance Plan benefits I receive?

You will not normally be taxed on your Dependent Care Assistance Plan benefits, up to the limits set out above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Are there any other limits on what Dependent Care Assistance Plan benefits are tax-free?

In addition to the dollar limitations discussed above, under the law the maximum amount of Dependent Care Assistance Plan benefits you may exclude from income during any calendar year cannot be more than--

(a) if you are not married as of the end of the year, your earned income for the year, or

(b) if you are married at the end of the year, the lesser of your earned income for the year, or your spouse's earned income. If your spouse is a full time student or is disabled, your spouse is considered under the federal tax rules as if he or she has a monthly earned income of \$200 (if Dependent Care Assistance Plan benefits are provided for only one dependent), or \$400 (if Dependent Care Assistance Plan reimbursements are made for two or more dependents).

Can I change my election for Dependent Care Assistance Plan benefits during the Plan Year?

Generally, you cannot change your election whether or not to participate in the Plan or vary the amount of benefits you have selected during the Plan Year, although your election will terminate if you are no longer working for your Employer.

There are some important exceptions to this general rule. You may change or revoke your previous Dependent Care Assistance Plan election at any time during the Plan Year if one or more of the following events occur:

- (a) your marriage, divorce, legal separation, or annulment;
- (b) the death of the your spouse or a dependent;
- (c) the birth, adoption, or placement for adoption of a child, as defined by the Internal Revenue Code;
- (d) the termination of employment (or commencement of employment) of you, your spouse, or your dependent;
- (e) the switching from part-time to full-time employment status, or from full-time to part-time status by you, your spouse, or your dependent;

- (f) the taking of an unpaid leave of absence by you, your spouse, or your dependent;
- (g) a change in the place of residence of you, your spouse, or your dependent;
- (h) a change in the work site of you, your spouse, or your dependent;
- (i) any other event that changes the employment status of you, your spouse, or your dependent, if the eligibility conditions for the cafeteria plan or other employee benefit plan of your employer or the employer of your spouse or dependent depend upon employment status and there is a change in that employment status with the consequence that one or more of you becomes or ceases to be eligible under the plan;
- (j) an event that causes your dependent to satisfy or fail to satisfy the coverage requirements, including age, student status, or other similar requirement of a benefit plan;
- (k) a change by your spouse or dependent under his or her employer's cafeteria or other benefit plan, allowing you to change your election on account of and corresponding with the change made by your spouse or dependent provided that (1) the plan of your spouse's or dependent's employer permits its participants to make an election change that is permitted under the law, or (2) the period of coverage under your plan with your Employer is different from the period of coverage under the plan of your spouse's or dependent's employer;
- (l) your Employer adds a new benefit package option or other coverage option or eliminates an existing benefit package option or other coverage option, allowing you to elect the newly added option or elect another option if an option has been eliminated and make corresponding election changes with respect to other benefit package options under the benefit plan which provide similar coverage;
- (m) If there is a significant increase or decrease in the cost of your work-related dependent care expenses, you are permitted to make a corresponding change to the amount of your dependent care election but only if the change in cost is imposed by a dependent care provider who is not an individual with respect to whom you may receive a deduction for tax purposes (which generally includes such individuals as your son or daughter, grandson or granddaughter or their descendants, stepson or stepdaughter, brother or sister (including half-blood siblings), stepbrother or stepsister, father or mother, grandfather or grandmother or their ancestors, stepfather or stepmother, niece or nephew, aunt or uncle, son-in-law or daughter-in-law, father-in-law or mother-in-law, brother-in-law or sister-in-law, whether natural relatives, adopted relatives or foster-placed relatives).

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

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although any amount of your qualified dependent care expenses not reimbursed under the Plan may be eligible for the dependent care credit. More information is available in IRS Publication 503 about this credit, or you should consult your own tax advisor.

What is the household and dependent care credit?

The Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability under the Code. Effective for tax years after 2010, a taxpayer claims this credit against federal income tax liability under the Code. A taxpayer may take into account \$2,400 of such expenses for one Dependent, or \$4,800 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of \$720 for one Dependent or \$1,440 for two or more Dependents), to a minimum of 20% of such expenses (producing a minimum credit of \$480 for one Dependent or \$960 for two or more Dependents). The maximum 30% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income that exceeds \$10,000.

Unless Congress amends Code Section 21, the changes made by the Economic Growth and Tax Relief Act ("EGTRRA") to the household and dependent care credit will sunset for tax years beginning after December 31, 2010. The amounts set forth in this question reflect the sunset of the EGTRRA provisions. Please contact your tax provider for more information.

Example:

Assume that you have one Dependent for whom you have incurred Dependent Care Expenses of \$3,600, and that your adjusted gross income is \$21,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$2,400 of the expenses. The highest percentage equals 30%. You must subtract 1% for each \$2,000 your adjusted gross income exceeds \$10,000. The calculation is $30\% - [(\$21,000 - 10,000)/\$2,000 \times 1\%] = 24\%$. In the end, your tax credit would be \$576 ($\$2,400 \times 24\%$). If you had incurred the same expenses for two or more Dependents, your credit would have been $\$3,600 \times 24\% = \864 , because the entire expense would have been taken into account, not just the first \$2,400.

You should consult IRS Publication No. 503 ("Child and Dependent Care Expenses") and your own tax advisor for more information.

When would I be better off to include Plan reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free, and forego coverage under the Dependent Care Assistance Plan?

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by not participating in the Plan and claiming the credits for dependent care and earned income on your tax return. On the other hand, it will generally be better to participate in the Dependent Care Assistance Plan the more the amount of income taxes you are required to pay. Because the actual determination of whether to participate in the Plan depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

What happens if my claim for Dependent Care Assistance Plan benefits is denied?

In the event your claim for benefits under the Dependent Care Assistance Plan is denied, the Plan Administrator will notify you in writing the reasons for the denial of benefits within 30 days of the date of the denial, and further advise you of any steps you may take to support your claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 30-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 30 days of the date of your request for a review.

What happens to any unused amounts remaining in my Dependent Care Assistance Plan Account?

Under the requirements of the federal tax law, any unused amounts credited to your Account as of the end of the Plan Year will be forfeited 90 days after the end of the Plan Year if you have not submitted a claim for eligible expenses incurred during the Plan Year, subject to any rights you may have under any Grace Period provided by your Employer. Likewise, if your employment with your Employer terminates during the Plan Year, your unused benefits will be forfeited the 90th day following your termination of employment if you have not submitted a claim for eligible expenses incurred before your date of termination.

MEDICAL REIMBURSEMENT PLAN QUESTIONS AND ANSWERS

Another major feature of your Employer's Cafeteria Plan is your opportunity to elect to receive income-tax-free reimbursement for some or all of your qualifying medical expenses which are not covered by insurance under your Employer's Medical Reimbursement Plan. Under the Plan, you provide a source of pre-tax funds to reimburse you for your eligible medical expenses by entering into a salary reduction arrangement with your Employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your salary reduction.

Who can participate in the Medical Reimbursement Plan?

Each person who is eligible to participate in the related Cafeteria Plan described above.

How do I become a Participant?

Once you are eligible to participate, you participate in the Plan by electing Medical Reimbursement Plan benefits on your Benefits Enrollment Form and executing a salary reduction agreement with your Employer. If you fail to execute any Benefits Enrollment Form for a Plan Year, you will be deemed to have elected to contribute \$0 to the Plan for that Plan Year.

How does the Medical Reimbursement Plan work?

That portion of your income which you apply to the Medical Reimbursement Plan will be credited to your Medical Reimbursement Plan Account ("Account") as of the first day of the Plan Year. For example, suppose you elect to apply \$1,300 of your income to the Plan, which amount is withheld from your pay throughout the entire Plan Year. Assuming you are paid every other week, your Employer will withhold \$50 from every paycheck. On the first day of the Plan Year, your Account will be credited with the entire amount of your election even though you have not actually contributed that amount to the Plan. The value of your Account will be reduced as you submit eligible expenses. Therefore, under the example, you are entitled to seek reimbursement of the full \$1,300 of your election as of the first day of the Plan Year.

Are there any limits on how much I can elect to contribute to my Account?

The maximum limit on your Medical Reimbursement Plan benefits is established by your Employer and is listed in the Introduction. Notwithstanding anything in this Summary Plan Description to the contrary, however, effective January 1, 2013 the Code limits the maximum benefit available under the Plan attributable to salary reduction contributions through the Cafeteria Plan to \$2,500 for any taxable year, plus any cost-of-living adjustment provided by Code section 125(i) or applicable Treasury Regulations for taxable years beginning after December 31, 2013.

Can I change my election for Medical Reimbursement Plan benefits during the Plan Year?

Generally, you cannot change your election whether or not to participate in the Plan or vary the amount of benefits you have selected during the Plan Year, although your election will terminate if you are no longer working for your Employer.

There are some important exceptions to this general rule. You may change or revoke your previous Medical Reimbursement Plan election at any time during the Plan Year if one or more of the following events occur:

- (a) your marriage, divorce, legal separation, or annulment;
- (b) the death of the your spouse or a dependent;
- (c) your birth, adoption, or placement for adoption of a child, as defined by the Internal Revenue Code;
- (d) the termination of employment (or commencement of employment) of you, your spouse, or your dependent;
- (e) an event that causes your dependent to satisfy or fail to satisfy the coverage requirements of a benefit plan, including age, student status or any other similar requirement;
- (f) a change in the residence of you, your spouse or your dependent; or
- (g) you, your spouse, or a Dependent: (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP. If one of these events occurs, you must request an election change to enroll in group health plan coverage within 60 days from the date (A) the coverage terminates under the Medicaid or SCHIP plan or (B) you or your Dependent is determined eligible for state premium assistance.

What happens to my Medical Reimbursement Plan benefits if I take a leave covered by the Family and Medical Leave Act?

You may continue or revoke your coverage under the Plan upon the occurrence of an FMLA Leave. You may only revoke your coverage under the Plan during the period of FMLA Leave if the duration of the FMLA Leave exceeds one month. If you revoke your coverage, upon return to employment following the FMLA Leave, you will be reinstated to your coverage under the Medical Reimbursement Plan, but the maximum amount of your reimbursements from your Account following your leave will be limited to the amount you originally elected for the Plan Year, minus amounts previously reimbursed during the Plan Year, minus amounts which you would have contributed by salary reduction during the time of the leave had your leave not occurred. Your salary reduction contributions will resume following your return from the leave at the same level as was in effect prior to the commencement of the leave, subject to adjustments as the result of an allowable change, as described in the question immediately above.

You may continue your coverage under the Medical Reimbursement Plan so long as you continue to pay to the Employer an amount equal to the amount of your periodic salary reductions that would have been made absent the occurrence of your leave. Coverage will terminate if you fail to make any such payment, subject to your right to reinstatement under the Plan after your leave, as described in the preceding paragraph. You may not be reimbursed for expenses incurred during a period in which your coverage under the Plan was not in effect. In

addition to allowing you to continue to make the payments during your leave, either by salary reduction if you are receiving Compensation during your leave, or by after-tax payment, the Plan Administrator may allow prepayments of required amounts. You should consult the Plan Administrator for more information.

How do I receive my benefits under the Plan?

When you incur a “qualified medical expense” that is eligible for payment, you should submit a claim to the Claims Administrator on a form that will be supplied to you. Your completed claim form should be submitted to the Claims Administrator by email, facsimile, or mail at the numbers and addresses provided above under the “Introduction”. Thereafter, regardless of how much has been withheld from your salary for Plan benefits, you will be reimbursed from your Account for your eligible expenses up to the maximum annual amount you elected to contribute to the Plan. You may not be reimbursed for any medical expenses that arise before your Benefits Enrollment Form becomes effective or for any expense incurred after the close of the Plan Year, subject to any rights available to you under any applicable Grace Period offered by your Employer.

The Claims Administrator may require you to provide additional documentation to substantiate your claim. If the Claims Administrator needs you to submit more information or your request has some other defect, the Claims Administrator will try to notify you within a reasonable time. The Claims Administrator will process claims for Qualified Medical Expenses when it receives your completed claim form and any required documentation. The Claims Administrator will reimburse you for the Qualified Medical Expenses when administratively feasible after it receives and has time to process the claim. If the Claims Administrator determines that the expense does not qualify as Qualified Medical Expense it will notify you of its decision.

When do I submit my claims?

You may submit claims for eligible medical expenses at any time during the Plan Year. In addition, you will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement of eligible expenses incurred during the previous Plan Year, subject to any rights you may have to participate in any Grace Period offered by your Employer. If your employment with your Employer is terminated, you have until the 90th day following the last day of your employment with the Employer to submit claims, unless you are eligible for continuation coverage under the Plan, in which case you will be notified by the Plan Administrator of the terms of your continued coverage. You will be notified in writing if any claim is denied.

What is the “Grace Period” and how do I make a claim for reimbursement of Qualified Medical Expenses incurred during the Grace Period?

Your Employer’s Medical Reimbursement Plan may allow you to be reimbursed from unused amounts remaining in your Medical Reimbursement Account at the end of a Plan Year for Qualified Medical Expenses incurred during a Grace Period following the end of the Plan Year. Any available Grace Period will begin on the first day of the new Plan Year and will end on the 15th day of the third month of the following Plan Year. Any unused amounts remaining in

your Medical Reimbursement Account at the end of the Grace Period are forfeited.

In order to take advantage of any Grace Period provided by your Employer, you must be a Participant in the Plan with Medical Reimbursement Plan coverage that is in effect on the last day of the Plan Year to which the Grace Period relates.

To the extent your Employer provides a Grace Period, the following additional rules apply to Qualified Medical Expenses that are incurred during the Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Qualified Medical Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume the Plan Year runs from January 1 to December 31. Assume further that \$200 remains in your Medical Reimbursement Account at the end of the 2010 Plan Year and that you have also elected \$2400 of Medical Reimbursement Plan coverage for 2011. If you submit a \$500 Qualified Medical Expense that was incurred on January 15, 2011, \$200 of your claim will be paid out of the unused amounts remaining in your Medical Reimbursement Account from the 2010 Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse you for Qualified Medical Expenses incurred in the 2011 Plan Year. Claims will be paid in the order in which they are approved.
- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the \$500 Grace Period expense, you discover \$200 of the 2010 Qualified Medical Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2010 expenses. The Plan will not reprocess the \$500 Grace Period expense so as to pay it entirely from your 2011 Medical Reimbursement Plan amounts. For this reason, if you have Medical Reimbursement Plan coverage for both the prior and current years you may want to wait to submit Qualified Medical Expenses you incur during the Grace Period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- Expenses incurred during a Plan Year or its Grace Period must be submitted by the end of the fourth month following the close of the Plan Year in order to be considered for reimbursement from amounts remaining at the end of that Plan Year. Unused amounts remaining in a Participant's Medical Reimbursement Account at the end of a Plan Year that are not applied to pay expenses submitted on or before this deadline will be forfeited.

What is a “qualified medical expense” for which I can seek reimbursement?

A qualified medical expense is any medical expense which you, your spouse or your dependents incur for medical care but only to the extent that the person incurring the expense is not reimbursed for the expense through insurance or otherwise. For this purpose, medical care means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for

the purpose of affecting any structure or function of the body, including transportation costs and certain lodging costs while away from home primarily for and essential to medical care.

Medical care does not include cosmetic surgery or similar procedures unless necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease. Medical care does not include premiums for other health or accident insurance or long term care insurance.

Who is a “dependent” for purposes of the Medical Reimbursement Plan?

A dependent generally is:

- (a) a spouse to whom you are legally married;
- (b) your child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (1) resides with you for more than half the calendar year; (2) does not provide over half of his or her own support for the taxable year; and (3) who is age 18 or younger;
- (c) your child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who is older than 18 years but younger than 24 years if that child: (1) is enrolled and participating as a full-time student at a high school or an accredited college, university, vocational, technical or trade school; (2) does not provide over half of his or her own support; and (3) has your residence as his or her principal place of abode for more than half of the calendar year;
- (d) your disabled child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (1) is not able to support himself or herself because he or she is mentally or physically incapable of working; (2) does not provide over half of his or her own support; and (3) resides with you for more than half of the calendar year;
- (e) a qualified relative who: (1) has a relationship with you as set forth by the IRS (such as parent, sibling, etc.); and (2) receives over half of his or her support from you for the calendar year; or
- (f) Effective January 1, 2011, your child (including step-child, adopted child, or foster child) who has not attained age 27 as of the end of the taxable year.

For purposes of determining who is your dependent under the Medical Reimbursement Plan, if you are divorced or legally separated, your child is considered a child of both parents regardless of who is the custodial parent.

May I withdraw cash from my Medical Reimbursement Plan Account?

No. Your account balance may be used only to provide reimbursement for eligible expenses.

How do I know when I “incur” a qualified medical expense?

For purposes of the Plan, an expense is incurred, and thereby eligible for reimbursement from your Account, on the date when the underlying medical services which give rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by you, your spouse or your dependent. You incur expenses for medicines and drugs on the date of purchase.

Are over-the-counter medicines and drugs reimbursable under the Plan?

Effective January 1, 2011, medicines and drugs, including over-the-counter and other nonprescription medicines and drugs other than insulin, will only be reimbursed if they are obtained pursuant to a prescription. The Medical Reimbursement Plan will only reimburse items that you obtain legally and are generally accepted as medicines and drugs. Medicines and drugs do not include items that are beneficial to the general health of an individual (vitamins, for example). Generally, toiletries, cosmetics and sundry items are not medicines and drugs. They only qualify if you, your Spouse, or your Dependent uses them for treating a specific medical condition pursuant to a doctor's note.

The Claims Administrator has discretion to determine what are medicines and drugs. You can only be reimbursed for a reasonable amount of medicines and drugs. If large quantities are necessary for the treatment of an existing condition, the physician's prescription must also indicate that the large quantity being purchased is necessary for the treatment of the diagnosed medical condition.

Will I be taxed on the Medical Reimbursement Plan benefits I receive?

You will not normally be taxed on your Medical Reimbursement Plan benefits, up to the limit set by your Employer.

If I participate in the Plan, will I still be able to itemize my medical care expenses on my federal income tax return?

You may not claim a deduction on your federal income tax return for the tax-free amounts you receive under this Plan, although you may be able to take a deduction for medical expenses not covered by this Plan. You should consult your own tax adviser for more information.

What happens if my claim for Medical Care Reimbursement Plan benefits is denied?

If your claim is wholly or partially denied, the Plan Administrator will notify you of this decision in writing within 30 days after your claim is received by the Plan Administrator. The notification will be written in a manner so you can understand it and will set forth (a) specific reasons for the denial, (b) specific reference to pertinent Plan provisions on which the denial is based, (c) a description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary, (d) information as to the steps to be taken if you wish to submit a claim for review, including a statement of your right to bring a civil action under Section 502(a) of ERISA if there is an adverse determination on

review; (e) if an internal rule or other similar criterion was relied upon to deny benefits, the internal rule or other similar criterion, or a statement that such rule or other criterion was relied upon in denying benefits and that a copy of such rule or other criterion will be provided free of charge to you upon request; and (f) if a denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon your request.

If special circumstances require an extension of time for processing your claim, written notice of the extension and expected determination date shall be given to you prior to the termination of the initial 30-day period. In no event shall the extension exceed a period of 15 days from the end of such initial period. In the event the Plan Administrator needs more information to process your claim, the Plan Administrator shall specifically describe the required information and you have 45 days from the date of such notice from the Plan Administrator to provide any additional information.

If your claim is denied, you or your authorized representative may (a) request a review upon written application to the Plan Administrator, (b) review pertinent documents, and (c) submit written comments, records, documents and other relevant information, which information shall be considered on appeal regardless of the initial benefit review. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents or other information relevant to your claim for benefits. You must file a request for review within 180 days after your receipt of written notification of the denial of your claim. The Plan will notify you of its decision in writing within 60 days after the request for review is received by the Plan Administrator.

The review on appeal shall not afford deference to the initial benefit review and must be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial that is the subject of the appeal or such person's subordinate. In deciding any appeal that is based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan will ensure that the health care professional engaged for purposes of such consultation is an individual who is neither an individual who was consulted in connection with the initial benefit determination nor the subordinate of any such individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your appeal without regard to whether the Plan relied upon such person's advice in making a benefit determination.

If your claim is wholly or partially denied on appeal, the Plan will notify you of its decision in writing. The notification will be written in a manner so you can understand it and will set forth (a) specific reasons for the denial, (b) specific reference to pertinent Plan provisions on which the denial is based, (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and other information relevant to your claim for benefits, (d) if an internal rule or other similar criterion was relied upon to deny benefits, the internal rule or other similar criterion, or a statement that such rule or criterion was relied upon in denying benefits and that a copy of such rule or other criterion will be provided free of charge to you upon request, and (e) 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.”

What rights do I have to continue my coverage under the Medical Reimbursement Plan in the event I lose coverage?

If you lose coverage under the Medical Reimbursement Plan because you incur a qualifying event, such as your termination or reduction in hours of employment, you may be able to continue your coverage in the Plan. Your Employer will provide you with a general notice of your continuation coverage rights at the time you begin participation in the Medical Reimbursement Plan. If you are entitled to continuation coverage under the Plan, your Employer will contact you and provide you more information on your rights.

What happens to any unused amounts remaining in my Account?

Under the requirements of the federal tax law, any unused amounts credited to your Account as of the end of the Plan Year will be forfeited 90 days after the end of the Plan Year if you have not submitted a claim for eligible expenses incurred during the Plan Year or otherwise submitted a valid claim under any Grace Period provided by your employer. Likewise, if your employment with your Employer terminates during the Plan Year, your unused benefits will be forfeited the 90th day following your termination of employment with the Employer if you have not submitted a claim for eligible expenses incurred not later than your date of termination.

What rights does ERISA provide me under the Medical Reimbursement Plan?

As a participant in Medical Reimbursement Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”), to the extent your plan is governed by ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- ☛ Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- ☛ Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- ☛ Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage.

- ⌘ Continue coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries.

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

Enforce Your Rights.

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

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

Assistance with Your Questions.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

HEALTH AND ACCIDENT INSURANCE PREMIUM REIMBURSEMENT PLAN
QUESTIONS AND ANSWERS

A feature of your Employer's Cafeteria Plan is your opportunity to elect to receive income-tax-free reimbursement for some or all of your premiums for individual health or accident insurance under the Employer's Health and Accident Insurance Premium Reimbursement Plan. Under this Plan, you provide a source of pre-tax funds to reimburse you for your eligible premiums of private insurance by entering into a salary reduction arrangement with your Employer in lieu of receiving a corresponding amount of your regular pay after-taxes. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your salary reduction.

Who can participate in the Health and Accident Insurance Premium Reimbursement Plan?

Each person who is eligible to participate in the Employer's Cafeteria Plan described above and who is not covered by a group health and accident plan maintained by the Employer is eligible to participate.

How do I become a Participant?

You participate in the Plan by electing Health and Accident Insurance Premium Reimbursement benefits on your Benefits Enrollment Form and executing a salary reduction agreement. If you fail to execute any Benefits Enrollment Form for a Plan Year, you will be deemed to have elected to contribute \$0 to the Plan for that Plan Year.

How does the Health and Accident Insurance Premium Reimbursement Plan work?

If you elect to participate in the Health and Accident Insurance Premium Reimbursement Plan, your Health and Accident Insurance Reimbursement Account under the Plan will be credited with that portion of your gross income you have elected to forego through salary reduction to the Plan. That portion of your income which you apply to the Health and Accident Insurance Premium Reimbursement Plan will be credited to your Account as of each pay period. For example, suppose you will pay \$2,400 in premiums to an individual health insurance plan during the plan year. Assuming you are paid twice a month, the cost of the above benefits per paycheck would be \$100. Your Health and Accident Insurance Reimbursement Account would be credited with a tax-free total of \$2,400, spread equally over 24 paychecks. The amount that you have set aside will accumulate until you submit a documented claim for reimbursement of eligible expenses.

What is my "Health and Accident Insurance Reimbursement Account?"

If you elect benefits under this Plan, a Health and Accident Insurance Reimbursement Account ("Account") will be set up in your name to keep a record of the amounts withheld pre-tax from your pay, to which you are entitled under the terms of the Plan.

What are the maximum Health and Accident Insurance Premium Reimbursement benefits I may elect?

There is no limit, subject to the prohibitions against discrimination described in the Cafeteria Plan.

What is an eligible expense for which I can claim a reimbursement?

You may be reimbursed for your "Private Health and Accident Insurance Expenses," which are premiums you incur to purchase insurance to reimburse you for expenses you incur for medical care for you, your spouse or your dependents, if you do not enroll under your Employer's group health plan. You must be the owner of any private insurance to obtain reimbursement for the premium payments. Premium payments for your spouse's or dependent's group health plan are not eligible expenses nor are premium payments for private insurance owned by your spouse or your dependent.

Who is a "dependent" for purpose of the Health and Accident Insurance Premium Reimbursement Plan?

A dependent generally is:

- (a) a spouse to whom you are legally married;
- (b) your child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (1) resides with you for more than half the calendar year; (2) does not provide over half of his or her own support for the taxable year; and (3) who is age 18 or younger;
- (c) your child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who is older than 18 years but younger than 24 years if that child: (1) is enrolled and participating as a full-time student at a high school or an accredited college, university, vocational, technical or trade school; (2) does not provide over half of his or her own support; and (3) has your residence as his or her principal place of abode for more than half of the calendar year;
- (d) your disabled child (including step child, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (1) is not able to support himself or herself because he or she is mentally or physically incapable of working; (2) does not provide over half of his or her own support; and (3) resides with you for more than half of the calendar year;
- (e) a qualified relative who: (1) has a relationship with you as set forth by the IRS (such as parent, sibling, etc.); and (2) receives over half of his or her support from you for the calendar year; or
- (f) Effective January 1, 2011, your child (including step-child, adopted child, or foster child) who has not attained age 27 as of the end of the taxable year.

For purposes of determining who is your dependent under the Health and Accident Insurance Premium Reimbursement Plan, if you are divorced or legally separated, your child is considered a child of both parents regardless of who is the custodial parent.

How do I receive my benefits under the Plan?

If you have elected to participate in this Plan, you must take certain steps to be reimbursed for your Private Health and Accident Insurance Expenses. When you incur an expense that is eligible for payment, you may submit a claim to the Plan Administrator on a form that will be supplied to you. If you have enough funds in your Health and Accident Insurance Reimbursement Account, you will be reimbursed for your eligible expenses. If your claim is for an amount that is more than your current Account balance, the excess part of the claim will be carried over into following months, to be automatically paid to you as your balance becomes adequate. Remember, though, that you cannot be reimbursed for any total expenses above your annual election amount. You must provide proof of payment of Private Health and Accident Insurance Expenses and proof that your private insurance was in force for the period for which you made the payment for which you seek reimbursement. You may not be reimbursed for any expenses that arise before your Benefits Enrollment Form becomes effective, or for any expense incurred after the close of the Plan Year. Please note that you must have actually paid an amount due for eligible expense in order to be reimbursed for it.

When do I submit my claims?

You may submit claims for eligible expenses at any time during the Plan Year. In addition, you will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement of eligible expenses incurred during the previous Plan Year. If your employment with your Employer is terminated, you have 90 days following the last day of your employment with the Employer to submit claims. You will be notified in writing if any claim is denied.

Will I be taxed on the Health and Accident Insurance Premium Reimbursement benefits I receive?

You will not normally be taxed on your Health and Accident Insurance Premium Reimbursement benefits but your Employer can make no guarantee of the tax consequences of the Plan. You should consult your own tax adviser.

Can I change my election for Health and Accident Insurance Premium Reimbursement benefits during the Plan Year?

Generally, you cannot change your election whether or not to participate in the Plan or vary the amount of benefits you have selected during the Plan Year, although your election to pay your premiums pre-tax will terminate if you are no longer working for your Employer.

There are some important exceptions to this general rule. You may change or revoke your previous Health and Accident Insurance Premium Reimbursement election at any time during the Plan Year under the same rules that apply to the insurance-type benefits of the Cafeteria Plan, as described above.

If I participate in the Health and Accident Insurance Premium Reimbursement Plan, will I still be able to claim a deduction for the premiums on my federal tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although any amount of your qualified expenses not reimbursed under the Plan may be eligible for deduction. You should consult your own tax advisor.

What happens to any unused amounts remaining in my Health and Accident Insurance Reimbursement Account?

Under the requirements of the federal tax law, any unused amounts credited to your Account as of the end of the Plan Year will be forfeited 90 days after the end of the Plan Year if you have not submitted a claim for eligible expenses incurred during the Plan Year. Likewise, if your employment with your Employer terminates during the Plan Year, your unused benefits will be forfeited 90 days following your termination of employment with the Employer if you have not submitted a claim for eligible expenses incurred not later than your date of termination.