

CAFETERIA PLAN
PREMIUM REDUCTION OPTION *PLUS*
FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY
PIEDMONT HEALTHCARE, INC

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SUMMARY PLAN DESCRIPTION

PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your employer identified in the Plan Information Summary (Part 9) (the "Employer") is pleased to sponsor an employee benefit program known as the Cafeteria Plan (the "Plan") for you and your fellow employees. It is so-called because it allows you to choose from several different benefit programs (which we refer to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes are deducted ("Pre-tax Contributions") to pay for the Benefit Options that you choose by entering into a salary reduction agreement with your Employer. This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). However, you may choose to pay for any of the available benefits with after-tax payroll deductions to the extent set forth in your enrollment materials.

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

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

PART 2. CAFETERIA PLAN SUMMARY

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

The purpose of the Cafeteria Plan is to allow eligible employees to pay for Benefit Options with Pre-tax Contributions. The Benefit Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Rules regarding Pre-tax Contributions are described in more detail below.

Q-2. Who can participate in the Cafeteria Plan?

Each Employee of the Employer (or an Affiliated Employer identified in Part 9, the Plan Information Summary) who satisfies the Plan's Eligibility Requirements and who is also eligible to participate in any of the Benefit Options will be eligible to participate in this Plan. If you meet these requirements, you may become a Participant on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants". (See below for instructions on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105(b)). The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

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

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

- (i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
- (ii) The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
- (iii) The date that you terminate employment with the Employer; or
- (iv) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will automatically cease, and you will not be able to make any more Pre-tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a pre-tax basis). If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are re-hired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or again become eligible within 30 days, your Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a participant?

If you have otherwise satisfied the Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-tax Contributions. You will be provided a Salary Reduction Agreement on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator or the Plan Service Provider (per the instructions provided with your Salary Reduction Agreement) during one of the election periods described in **Q-6.** below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8.** below. The Plan Service Provider is identified in the Plan Information Summary.

In some cases, the Employer may *require* you to pay your share of the Benefit Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan. NOTE: Although coverage under a Benefit Option may be retroactively effective, the Pre-tax Salary Reduction elections made under this plan are typically effective on a prospective basis only.

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

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

You save federal income tax, FICA (Social Security) and state income taxes (where applicable) by participating in the Plan. Consider the following example to illustrate the potential tax savings under a cafeteria plan:

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

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	\$50,000		\$50,000
2. Salary Reductions for Premiums	\$2,400 (pre-tax)		\$0
3. Adjusted Gross Income	\$47,600		\$50,000
4. Standard Deduction	(\$10,300)		(\$10,300)
5. Exemptions	(\$9,900)		(\$9,900)
6. Taxable Income	\$27,400		\$29,800
7. Federal Income Tax (Line 6 x applicable tax schedule)	(\$3,359)		(\$3,719)
8. FICA Tax (7.65% x Line 3 Amount)	(\$3,641)		(\$3,825)
9. After Tax Contributions	(\$0)		(\$2,400)
10. Pay after taxes and contributions	\$40,600		\$40,056
11. Take Home Pay Difference	\$544		

Plan participation will reduce the amount of your taxable compensation. However, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation.

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

The Cafeteria Plan basically has three election periods: (i) the "Initial Election Period," (ii) the "Annual Election Period," and (iii) the "Election Change Period, which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and

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

6b. What is the Annual Election Period?

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

The Plan Year is generally a 12-month period (a short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

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

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-tax Contributions. Alternatively, your Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have the option to pay with after-tax contributions.

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

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

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

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

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

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

- (a) You experience a "Change in Status Event" that affects your eligibility under this Plan and/or a Benefit Option; or
- (b) You experience a significant cost or coverage change; and
- (c) You complete and submit a written Election Change Form to the Plan Service Provider within 30 days of the event.

Third, an election under this Plan may be unilaterally modified by the Employer during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) as necessary to prevent the Plan from failing the applicable non-discrimination rules set forth in the Code.

The following is a summary of the applicable Change in Status Events and cost or coverage changes. Note: These rules do not apply to a Code Section 223 Health Savings Account offered

under the Cafeteria Plan. See Part 7 below for more information regarding election changes related to the Health Savings Account.

1. Changes in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
- Change in the number of your tax Dependents or eligible Dependent children (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,
- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a certain age), or
- Change in your, your Spouse's, or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of, and corresponds with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is still a tax dependent or your child (e.g. a child who has lost eligibility under the Plan). [Note: You cannot pay for COBRA coverage from your Health FSA.]
- *Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election

to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care FSA Benefits.* With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

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

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect to either increase or decrease coverage.

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

2. Special Enrollment Rights. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, exhaustion of COBRA period, or if your employer or your eligible dependent's employer stops contributing toward your or your dependents' other coverage), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be

able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

In addition, if an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or CHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Thus, for example, if an otherwise eligible Employee has medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

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

4. Entitlement to Medicare or Medicaid. If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. Change in Cost. If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive

coverage under another Benefit Package Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are met. The Change in Cost provisions do not apply to Health FSA benefits.

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

6. Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are satisfied. The Change in Coverage provisions do not apply to Health FSA benefits.

7. Reduction in hours below 30 hours of service per week due to change in employment status without loss of eligibility. You can drop major medical coverage for yourself, your spouse, and/or your dependents if:

- You were in an employment status where you were reasonably expected to work at least 30 hours per week *and* there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the major medical plan; and
- Your revocation of the election of coverage under the major medical plan corresponds to the intended enrollment of you, your spouse, and your dependent(s)

(as applicable), in another plan that provides minimum essential coverage effective no later than the first day of the second month after the month that includes the date this coverage is revoked.

You can only drop major medical coverage due to this event and cannot drop any other coverage (including but not limited to health FSA coverage) unless another election change event is available for that benefit.

7. Qualified Health Plan Coverage. You can drop major medical coverage for yourself, your spouse, and/or your dependents if:

- You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- The revocation of the election under the major medical plan corresponds to the intended enrollment of you, your spouse, and your dependent(s) who revoked coverage in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of major medical plan coverage.

You can only drop major medical coverage due to this event and cannot drop any other coverage (including but not limited to health FSA coverage) unless another election change event is available for that benefit.

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

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

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

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Options) during a leave of absence. The specific election changes that you can make under this Plan following a leave of absence are described in the Status Change Matrix and the rules regarding coverage under the Benefit Options during a leave of absence will be

described in the Benefit Option summaries. If there is a conflict between the Status Change Matrix/Benefit Option Summaries and this Q-9, the Status Change Matrix or Benefit Option summary, whichever is applicable, controls.

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- (c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:
 - (i) With after-tax dollars while you are on leave,
 - (ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).
 - (iii) By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Election Change Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be

automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- (g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

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

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

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

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

PART 3. CASH BENEFITS

During any one Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan (as identified in Part 9 below). Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Except to the extent set forth in the Enrollment material, any Benefit Credits not used towards the cost of Benefit Options made available under the Plan will revert back to the employer.

PART 4. HEALTH CARE PREMIUM REIMBURSEMENT BENEFITS

If listed as a Benefit Option offered under the Plan in Part 9 below, you can elect to allocate pre-tax salary reduction amounts for reimbursement of health care premiums (HCPR).

Q-1 Who can elect Health Care Premium Reimbursement (HCPR)?

If you are eligible to be a participant in the Cafeteria Plan, you can elect to make pre-tax salary reductions for certain employer approved individual insurance policies. If you do make a proper election, amounts equal to Health Care Premium Expenses that you incur or pay will be withheld from your pay and you will be reimbursed (either directly or indirectly) for such expenses with these amounts.

Q-2 What are Health Care Premium Expenses?

Health Care Premium Expenses are the premiums that you pay for an individual insurance policy(ies) that you purchase outside of any employer plan. Such expenses must meet the following conditions: (a) the individual insurance policy must be determined by the Plan Administrator to be a “Qualified Benefit” before the beginning of the Plan Year or, if you are a new hire, before the effective date of your participation in the Plan. For purposes of the HCPR, a Qualified Benefit is an individual insurance policy that provides accident and health insurance described in Code Section 106 (individual major medical policies obtained through the Health Insurance Marketplace or “Exchange” do not qualify), (b) the contract must be an individually purchased contract and not an employer-sponsored insurance plan; and (c) you must be the policyholder of the insurance policy. Please note that Health Care Premium Expenses do not include premiums paid to obtain individual major medical policies through the Health Insurance Marketplace or “Exchange,” which under IRS guidance cannot be paid on a pre-tax basis through this Plan.

Q-3 How do I become a Participant?

During the applicable Enrollment Periods described in Part 2, Q-6 you must submit a Salary Reduction Agreement wherein you elect the amount you want withheld for reimbursement of Health Care Premium Expenses. In addition, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased for yourself outside of any employer plan and (b) indicate on the Salary Reduction Agreement the premium amount that you will expect to pay during the Plan Year for such policy. The Plan Administrator will notify you if the insurance policy is determined to be a “Qualified Benefit” under the Plan. See Part 9 below for your effective date of participation. The effective date of coverage may vary by Enrollment Period.

If you elect Health Care Premium Expense Reimbursement (HCPR), a record will be kept of all salary reductions made for reimbursement of Health Care Premium Expenses as well as all actual reimbursements.

Q-4 What happens if I fail to return my Salary Reduction Agreement?

If you fail to return a Salary Reduction Agreement electing Health Care Premium Reimbursement (whether you are currently participating or not) before the end of the applicable Enrollment Period, it will be assumed that you have elected to forgo Health Care Premium Reimbursement (HCPR) and receive an equal amount of your pay as taxable compensation. See Part 2. Q-6 above for further discussion regarding elections.

Q-5 How do I receive Reimbursement under a Health Care Premium Reimbursement Program?

If you elect to participate in the HCPR, you will have to take certain steps to be reimbursed for your Eligible Health Care Premium Expenses. You will be supplied with the necessary claim forms. In addition to the claim form, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Eligible Health Care Premium Expenses for which you are requesting reimbursement unless the Employer is paying the carrier directly. In that case, you must submit a statement or invoice from the carrier indicating the amount of the premium and the period of coverage. If the Employer is paying the carrier directly, the insurance carrier will be paid the premium (up to the amount of pre-tax contributions you have set aside for that period) in the next check processing cycle. Your Plan Administrator will advise you how often the checks are processed. The Employer, the Plan, the Plan Administrator, and the Plan Service Provider are not responsible for any coverage that you lose for failure to pay a premium if your salary reduction election for Health Care Premium Expenses is insufficient to cover the premium amount.

The salary reduction amount for such benefits cannot exceed the amount of premiums you are required to pay for such coverage. The amount of your reimbursement cannot exceed the amount of your salary reductions made at that time for Eligible Health Premium Expenses, reduced by prior reimbursements. If your salary reduction amount to date is equal to or less than your claim, your claim for eligible expenses will be reimbursed in full. If the amount that you have salary reduced is less than your claim amount, the excess part of the claim will be carried over into the following pay cycles during the year (or as otherwise permitted by applicable law) to be paid up to your balance. In other words, as additional salary reduction amounts are made, a reimbursement check will be processed automatically for any unpaid portions of any previously submitted claims (to the extent such claims are eligible for reimbursement). Remember, no expenses can be reimbursed that exceed the salary reductions you have made up to that date reduced by any previous reimbursements. You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Salary Reduction Agreement becomes effective, or after the end of the Plan Year (or as otherwise permitted by applicable law), whichever is applicable. Also, no reimbursement will be provided if the reimbursement amount is less than the Minimum Check Amount (specified in Part 9, the Plan Information Summary (if any)). The Minimum Check Amount will not apply for processing the final checks during any Plan Year. At the end of the Plan Year, you will have a Run-Out period (as stated in Part 9, the Plan Information Summary) to turn in claims for premiums incurred during the Plan Year. No claims

can be submitted for reimbursement after that time. Your Employer may set a different claims submission grace period for terminated employees; if so, you will find this information in Part 9.

Q-6 Can I change the election during the year?

You can change elections during the year only if you experience one of the Change in Status events listed in Part 2, Q-8 and follow the procedures outlined within that section.

Q-7 What happens if my salary is reduced more than my actual Health Care Premium Expenses at the end of the Plan Year?

The cafeteria plan rules prohibit the return of any salary reductions that are not used for Health Care Premium Expenses incurred during the Plan Year (or as otherwise permitted under the applicable law).

The Employer will use the forfeitures to offset administration expenses. Also, any uncashed reimbursement checks will be forfeited if not cashed within 90 days of issue.

PART 5. HEALTH FSA SUMMARY

Q-1. Who can participate in the Health FSA?

Each Employee who satisfies the Eligibility Requirements and who is eligible to participate in the Employer's major medical plan is eligible to participate on the Plan Entry Date. The Eligibility Requirements and Plan Entry Date are described in Part 9, the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Eligibility requirements, you become a participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in Part 2, the Cafeteria Plan Summary. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

You may also become a participant if you experience a change in status event that permits you to enroll mid-year (see **Q-8.** of Part 2, Cafeteria Plan Summary, for more details regarding mid-year election changes and the effective date of those changes).

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

- (i) Your legal Spouse (as determined in accordance with federal law);
- (ii) Your child, until the end of the year in which your child turns age 26; and

- (iii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

For purposes of (ii) above, your “child” means your son, daughter, stepchild, foster child, legally adopted child, or child placed with you for legal adoption, regardless of such child’s tax dependent status, marital status, employment status, student status or residency. If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons (“alternate recipients”) named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. “Alternate recipients” include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A “medical child support order” is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan’s procedures governing qualified medical child support orders.

NOTE Employee and child(ren) only Election: Your participation in this Health FSA could disqualify your spouse from establishing and making/receiving tax favored contributions to a health savings account as defined in Code Section 223 unless you have elected the limited reimbursement option set forth below. If a spouse maintains a Code Section 223 health savings account or wishes to establish a Code Section 223 health savings account, you may make an election during the initial enrollment period and/or the annual enrollment period to exclude your spouse from coverage under the Health FSA and cover only the participant and the participant’s eligible dependents (but only to the extent identified as an option in Part 9, the Plan Information Summary).

Q-3. What is my “Health Care Account”?

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

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

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

- (i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;

- (ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
- (iii) The date that you no longer satisfy the Health FSA Eligibility Requirements;
- (iv) The date that you terminate employment; or
- (v) The date that the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in **Q-17.** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

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

- (i) The date your coverage ends;
- (ii) The date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);
- (iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

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

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

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

- (i) *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- (ii) *Following a Change In Status Event.* You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8.** of Part 2, the Cafeteria Plan Summary, for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes.**

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

Refer to Q-9, Part 2 of the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either (a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or (b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

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

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. The maximum salary reduction contribution that can be made to the Health Care Reimbursement Account for any Plan Year shall be \$2500 (as indexed for inflation for future years) or such lesser amount as is communicated in the Plan Information summary or enrollment materials. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

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

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

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

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement)

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

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

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

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

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

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or prescribed over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Plan Service Provider will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an “Eligible Medical Expense” you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run-Out Period following the end of the Plan Year (or if applicable, the Claims Submission Grace Period following the date that you cease to be a participant). The Run-Out Period (and the Claims Submission Grace Period) is described in Part 9, the Plan Information Summary.

You may have a claim submitted by means of a provider supplied electronic claim file (“Import”). In other words, the claim is provided directly to the Plan Service Provider by the provider or health plan. In that case, you do not need to file a claim with the Plan Service

Provider; it is deemed filed when the Plan Service Provider receives the claim. You will be notified in the enrollment material of this Plan or the applicable Benefit Option if claims will be provided directly to the Plan Service Provider of this Plan. If you elect this option when made available to you, you must hereby agree not to seek reimbursement for an imported claim from any other source.

Electronic Payment Card. Alternatively, you may be able to use, if enabled as a Plan option in Part 9, the *mySourceCard*[®] MasterCard[®] Debit Card (“*mySourceCard*[®]”) to pay the expense. In order to be eligible for the *mySourceCard*[®], you must agree to abide by the terms and conditions of the *mySourceCard*[®] Program (the “Program”) as set forth in Part 8 and in the *mySourceCard*[®] Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc.

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

An “Eligible Medical Expense” is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

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

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. However, over-the-counter drugs and medicines can only be reimbursed if a valid prescription relating to such OTC medicines and drugs has been obtained. Over-the-counter products and devices other than drugs or medicine will still constitute an Eligible Medical Expense even if not prescribed by a physician. Not every health related expense you or your eligible dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care”, as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. “Stockpiling” of over-the-counter drugs (even with a prescription) and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

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

- Health insurance premiums;
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

If you currently maintain or wish to establish a personal Health Savings Account (Limited Reimbursement Option), you may be able to make an election to limit the scope of your coverage as set forth below but only to the extent Limited Scope Coverage is identified as an option in the Plan Information Summary.

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute “medical care” as defined in Code Section 213(d)):

- (i) Services or treatments for dental care (excluding premiums)
- (i) Services or treatments for vision care (excluding premiums)
- (ii) Services or treatments for “preventive care” Preventive care is defined in accordance with applicable rules and regulations. This may include any prescribed drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic), (b) to prevent the recurrence of a condition from which the eligible individual has recovered, or (c) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

To the extent identified as an option in the Plan Information Summary (Part 9), you may elect the limited-scope health FSA during Initial and/or Annual Enrollment Period.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the “grace period,” if adopted, will be described in Part 9, the Plan Information Summary.

In lieu of adopting a grace period, the Employer may instead permit you to carryover from year-to-year up to \$500 of amounts allocated to a Health Care Account that are unused at the end of the Plan Year for expenses incurred in the next Plan Year. The terms of the “carryover,” if adopted, will be described in Part 9, the Plan Information Summary.

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

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

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. If the Employer instead adopted a carryover, up to \$500 of the unused amount remaining at the end of the Plan Year can be carried over to the next Plan Year and used to reimburse expenses incurred during the next Plan Year.

Any amounts not used for expenses incurred during the Plan Year and during the grace period, or that are not permitted to be carried over, will be forfeited. The sole exception to this rule is the “Qualified Reservist Distribution,” described in Q-14.

Q-14 What is a “Qualified Reservist Distribution”?

If the Employer has adopted a Qualified Reservist Distribution, you may be able to receive a taxable distribution of amounts allocated to the Health FSA that are unused in the event you are called to active duty if you meet the following criteria:

- You are a member of a “reserve component” (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; the Reserve for the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard; Air National Guard of the United States; or the Reserve Corps of the Public Health Service;
- You are called or ordered to active military duty for (i) 180 days or more or (ii) for an indefinite period;
- You provide a copy of your order or call to active duty; and
- You are a Participant in the Health FSA on the date you are called or ordered to duty.

If Employer has adopted the Qualified Reservist Distribution and you believe you are eligible for a Qualified Reservist Distribution, you must contact the Plan Administrator to request a distribution request form as soon as possible. A request for a Qualified Reservist Distribution must be made in writing on the form provided by the Plan Administrator. You must submit a copy of your order or call to active duty along with your request. Requests for a Qualified Reservist Distribution must be made on or after the date of the order or call to duty but before the last day of the Plan Year (or grace period, if applicable) during which the order or call to duty occurred. You will receive your Qualified Reservist Distribution within a reasonable period of time, but no later than sixty (60) days after your request has been received.

A Qualified Reservist Distribution will be made based on all salary reduction amounts credited to your Health FSA for the applicable Plan Year that have not been applied to provide Health Care Reimbursements submitted before the Qualified Reservist Distribution request is submitted. Notwithstanding anything to the contrary, if you elect to receive a Qualified Reservist Distribution, you may continue to submit reimbursement requests for eligible expenses incurred after the Qualified Reservist Distribution but before the end of the Plan Year, provided that the aggregate amount of claims reimbursed cannot exceed the difference between the Qualified Reservist Distribution and the annual election.

Claims incurred and submitted but not yet reimbursed at the time the Qualified Reservist Distribution Request is received will be treated like any other claim submitted for reimbursement under the Health FSA.

The Plan Administrator will determine what this amount is on a uniform basis, consistent with applicable law and IRS interpretations. Notwithstanding any other provision of this Plan, an individual who has selected a Qualified Reservist Distribution shall be considered to have made such election as an alternative to COBRA or USERRA coverage continuation for the Health FSA (except as may otherwise be required by applicable law).

Unlike your reimbursements from your Health FSA for Eligible Medical Expenses, the amount of your Qualified Reservist Distribution is taxed as income and will be reported as income on your W-2.

Qualified Reservist Distributions do not apply to amounts in your Dependent Care FSA.

Whether your Employer has adopted the Qualified Reservist Distribution is indicated in Part 9 of the Plan Information Summary.

Q-15. What happens if a Claim for Benefits under the Health FSA is denied?

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

Q-16. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) within 90 days after reimbursement is made shall be forfeited.

Q-17. What is COBRA continuation coverage?

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

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse, and/or covered dependent child at the time of the qualifying event.

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

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of	√	√	√

employment			
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

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

Type of Continuation Coverage

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

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

Notice Requirements

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

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

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

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

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

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

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

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements

in one or more of the following ways during the Plan Year that you receive an excess repayment: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement; or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-19. Will my health information be kept confidential?

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

Q-20. How long will the Health FSA remain in effect?

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

Q-21. How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) Sponsored by the Employer? (Only if Applicable)

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

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review **Q-17** of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Assistance with Your Questions

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

PART 6. DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1. Who can participate in the Plan?

Each employee who satisfies the Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in Part 9, the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Eligibility Requirements, you become a participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Q-6.** of Part 2, the Cafeteria Plan Summary. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year (see **Q-8.** of Part 2, the Cafeteria Plan Summary, for more details regarding mid-year election changes and the effective date of those changes).

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

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

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

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

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

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

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

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

- (i) *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
- (ii) *Following a Change In Status Event or Cost or Coverage Change.* You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant cost or coverage change. See **Q-8.** of Part 2, the Cafeteria Plan Summary, for more information on election changes.

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

Refer to Q-9, Part 2 of the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence.

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

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

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

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

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

- (i) physically or mentally incapable of caring for himself or herself, or
- (ii) a full-time student (as defined by Code Section 21).

Q-8. How Do I Pay for Dependent Care Reimbursements?

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

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement).

Q-9. What is an "Eligible Day Care Expense" for which I can claim a reimbursement?

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

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

- (i) An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying

child” is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support; or

- (ii) a Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

Note: there is a special rule for children of divorced parents. The child is a qualifying individual of the “custodial parent”, as defined in Code Section 152(e).

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

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

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

6. The expense is not paid or payable to a “child” (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by a parent of the Qualifying Individual.

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

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

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

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

Traditional Paper Claims: If you have elected to participate in the Dependent Care FSA, you must take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. You may obtain a Request for Reimbursement form from the Plan Administrator or Plan Service Provider. You must include this form with your request for Reimbursement. If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

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

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

Electronic Payment Card. Alternatively, you may be able to use, if enabled as a Plan option in Part 9, the *mySourceCard*® MasterCard® Debit Card (“*mySourceCard*®”) to pay the expense. In order to be eligible for the *mySourceCard*®, you must agree to abide by the terms and conditions of the *mySourceCard*® Program (the “Program”) as set forth in Part 8 and in the *mySourceCard*® Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc.

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

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

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for

expenses incurred during the grace period following the end of the Plan Year. The terms of the “grace period”, if adopted, will be described in the Plan Information Summary.

Q-12. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

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

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and the grace period will be forfeited.

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

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

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

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

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

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment

Related Expenses (to a maximum credit amount of \$1,050 for one Qualifying Individual or \$2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income over \$15,000.

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

Q-16. What happens to unclaimed Dependent Care Reimbursements?

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

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

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

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

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

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

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

PART 7. HEALTH SAVINGS ACCOUNTS

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

A Health Savings Account (“HSA”) is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of “eligible medical expenses” you (the Account Beneficiary) and your eligible tax dependents (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) incur, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee, and the terms of the HSA are set forth in the Custodial or Trust Agreement. The HSA is not an Employer sponsored employee benefit plan. The Employer’s role with respect to the HSA is limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited to the Account Beneficiary’s HSA. As such, the HSA identified in the Plan Information Appendix is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Q-2. Who is eligible for an HSA?

Only individuals who satisfy the following conditions on the first day of a month are eligible for an HSA offered under this Plan for that month:

- a. You are covered under a qualifying High Deductible Health Plan (HDHP) maintained by your Employer;
- b. You have opened an HSA with the Custodian chosen by the Employer;
- c. You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage [Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not (including but not limited to coverage maintained by your spouse’s employer, such as coverage under a spouse’s general purpose health flexible spending account or medical plan) and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223] and
- d. You cannot be claimed as a tax dependent by anyone else;
- e. You are not enrolled in Medicare coverage; and
- f. You are otherwise eligible for this Plan.

Q-3. Who is an Account Beneficiary?

An Account Beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable Custodial Agreement.

Q-4. Who is a Custodian or Trustee?

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

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

Contributions made under this Plan may consist of both employee pre-tax contributions made pursuant to a Salary Redirection Agreement and/or non-elective Employer contributions (if any). You may elect to contribute any amount to the HSA that you wish; however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer non-elective contributions and pre-tax salary reductions) during the Plan Year cannot exceed the sum of monthly limits for each month during the Plan Year that you are an eligible individual (as described in Q-2 above). The monthly limit is 1/12 of the maximum amount set forth in Code Section 223(b).

If the Account Beneficiary will be age 55 or older before the end of the tax year, and the Account Beneficiary properly certifies his or her age to the Employer, the maximum contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b)(3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the Custodian.

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

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

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

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

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

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

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

PART 8. mySourceCard®

The Electronic Payment Card allows you to pay for Eligible Expenses as defined by the Plan(s) in which you participate at the time that you incur the expense. Here is how the Electronic Payment Card works, if indicated as an option under the Plan in Part 9 below.

- (a) *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the Program, limitations as to card usage (it can not be used at all MasterCard® acceptance locations and has no cash assess), the Plan’s right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you when your card is provided to you. The card will be effective the first day of each Plan Year unless you do not affirmatively opt-out of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

- (b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.
- (c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify, during the applicable Election Period, that the card will only be used for Eligible Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
- (d) *Reimbursement under the card is limited to specific providers.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.) identified by the Plan Administrator or its designee as an eligible merchant. In addition, the Card will be administered in accordance with applicable IRS guidance. Use of the card for DCAP expenses is limited to merchants who are child card providers. Use of the card for other Plan expenses may be limited to merchants of qualified classifications. The card can not be used at all MasterCard® acceptance locations.
- (e) *You swipe the card at the provider like you do any other credit or debit card.* When you incur an Eligible Expense at a qualified merchant, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Plan is being made is an Eligible Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source. If you are using the card for DCAP expenses, you certify that you are using the card for services already incurred (and the payment is not made in advance of the date services will be provided).
- (f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:
- The nature of the expense (e.g., what type of service or treatment was provided).
If the expense is for an over the counter item other than a drug or medicine (e.g., bandages), the written statement must indicate the name of the item. If the name of the item is abbreviated heavily, please include a copy of the box top or packaging so the receipt abbreviation can be tied to the actual

over-the-counter item purchased.. If the expense is for a DCAP payment, the written statement must indicate the tax ID number of the provider.

- The date the expense was incurred or the period during which the services were provided (for example, DCAP expenses should show the period during which the services were provided if payment is made for than one day).
- The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement or as otherwise permitted under applicable law and associated guidance). You will receive written notice from the Plan Service Provider that a third party statement is needed in order to substantiate the expense. If requested by the Plan Service Provider, you must provide the third party statement within 21 days (or other period specified in the notice) of the request.

- (g) *There are situations where the third party statement will not be required to be provided to the Plan Service Provider.* There are many situations in which you will not be required to provide the written statement to the Plan Service Provider. Situations in which you may not be required to submit the third party statement are detailed in the Cardholder Agreement.

Note: You must obtain the third party receipt for ALL card transactions when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Plan Service Provider or the IRS requests it.

- (h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Plan Service Provider, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is determined by the Plan Administrator. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Plan. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement), or the remaining unpaid amount will be included in your gross income as taxable “wages”.

- (i) If the Plan Administrator decides to offer electronic payment cards as a payment option under the Dependent Care FSA, you may only use the Card to pay for Eligible Day Care Expenses incurred after you have properly substantiated an initial Day Care expense (the “Original Day Care Expense) for which you do not receive reimbursement under the Plan. Once you have “incurred” the Original Day Care Expense at a particular day care provider, you should submit the appropriate substantiation regarding this expense to the Third Party Administrator

on or after the period during which the day care provider provided services or treatments (the “Service Duration”). If the Original Day Care Expense is determined to be an Eligible Day Care Expense, the Third Party Administrator will allocate to your Card an amount equal to the lesser of the amount of the Original Day Care Expense or the Dependent Care Account balance. The Third Party Administrator will continue to allocate amounts equal to the lesser of the Original Day Care Expense or your Dependent Care Account balance each time you use the card at the same day care provider, for the same or lesser amount, and during the same Service Duration periods. Any increase in the amount, day care provider and/or service duration period will require you to begin the process over with a new Original Day Care Expense before you can use the Card again.

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

IMPORTANT: Over the counter (OTC) drugs and medicines can only be reimbursed if a valid prescription relating to such OTC medicines and drugs has been obtained. In order to ensure compliance with this requirement, you have two options:

- i) For participants using health debit cards at a SIGIS participating pharmacist, you must present your prescription to the pharmacist at the time and point of sale. The pharmacist will process the transaction using your health debit card.
- ii) For participants filing paper claims and/or purchasing drugs at a non-SIGIS participating pharmacy, you must submit a pharmacy receipt with an RX number or a copy of the written prescription with your request for reimbursement.

If the above requirements are met, and the OTC medicine or drug is otherwise an eligible medical expense, the claim will be processed. Note: a prescription is not required for eligible OTC medical items other than medicines or drugs (e.g., bandages, contact lens solution, etc).

PART 9. PLAN INFORMATION SUMMARY

1. Employer Organization

Name of Organization:	Piedmont Healthcare, Inc
Federal Employer ID Number:	58-0566213
Date Incorporated:	06/01/2003
Mailing Address:	2727 Paces Ferry Road Bldg 2, Suite 900
City, State, Zip:	Atlanta, GA 30339
Street Address:	2727 Paces Ferry Road Bldg 2, Suite 900

City, State, Zip: Atlanta, GA30339
Form of Organization: Non-Profit Corporation
Organized in the state of: GA

Employer Affiliates:

2. Plan Elections

Plan Number: 501
Plan Name: Section 125 Cafeteria Plan
Original Effective Date: 01/01/2016
Plan Year Runs*: 01/01 - 12/31
Plan Restated and Amended: / /

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator: Piedmont Healthcare, Inc
Plan Service Provider: O.C.A. Benefit Services
Street Address: 3705 Quakerbridge Road
Suite 216
City, State, Zip: Mercerville, NJ 08619
Contact:
Phone: (609) 514-0777

Benefits Coordinator

Name: Jeffrey Bevil
Title:
Phone: (678) 503-1915
Company Name: Piedmont Healthcare, Inc
Street Address: 2727 Paces Ferry Road
Bldg 2, Suite 900
City, State, Zip: Atlanta, GA 30339

Acceptance of Legal Process

Name: Jeffrey Bevil
Title:
Phone: (678) 503-1915
Company Name: Piedmont Healthcare, Inc
Street Address: 2727 Paces Ferry Road
Bldg 2, Suite 900
City, State, Zip: Atlanta, GA 30339

The appointed Plan Service Provider in conjunction with the Plan Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

3. Eligibility Requirements

- a) Except as provided in (b) below, the Classification of Eligible Employees consists of All employees (note that Eligible Employees must be eligible for Employer's major medical coverage to participate in the Health FSA).
- b) Employees excluded from this classification group are those individual employees who fall into one or more of the following categories below:

No Exclusions.

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

Service Period Requirement

For All plan years, eligibility is the following:

1st of the month following 30 days of employment.

4. Annual Election Rules.

With respect to pre-tax salary reduction elections (other than the Health FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in the one of following deemed election(s):

[X] The employee will be deemed to have elected not to make pre-tax salary reductions during the subsequent plan year.

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

5. Plan Entry Date

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement during the applicable Enrollment Period or Date requirements are met..

6. Benefit Package Options

The following Benefit Package Options are offered under this Plan:

Core Health Benefits.

The terms, conditions, and limitations of the Core Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

Non-Core Supplemental Plans.

The terms, conditions, and limitations of the Non-Core Supplemental Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies. (Dental and Vision)

Unreimbursed Medical Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the plan, and on or before the first day of any plan year thereafter, to be reimbursed from the employer for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Document.

Dependent Care Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the plan, and on or before the first day of any plan year thereafter, to be reimbursed from the employer for dependent care cost incurred during that year by him to the extent described in the Plan Document.

7. Flexible Spending Account Elections-Run-Out

Run-Out

A. The Active Employee Run-Out is the period of time that begins the day after the Plan Year ends during which the employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. See Part 9, Sec. 9 for Run-Out information.

B. The Terminated Employee/Coverage Run-Out is the period of time after an employee terminates employment (or loses eligibility to participate in the Plan) during which the employee can submit claims for expenses incurred while the employee remained a participant. See Part 9, Sec. 9 for Run-Out information.

Amounts contributed for reimbursement benefits are segregated for record keeping and accounting purposes only, and this process does not constitute a separate fund or entity as the reimbursements are made from the general assets of the plan sponsor.

A. Health FSA

- (a) The maximum annual reimbursement amount an Employee and Employer may elect for any Plan Year is \$ 0.00 (not to exceed \$2500 (as indexed and as pro-rated for any short Plan Year))...

- (b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.
- (c) Minimum Contribution for this Benefit per Plan Year per Employee is \$0.00.
- (d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except those claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as \$0.00
- (e) COBRA Administrator: _____
Street Address: _____

City, State, Zip: _____, _____
- (f) **Limited-Scope Option:** Employees may elect during the initial enrollment period and/or the annual enrollment period the limited-scope option of reimbursement under the Health FSA, as set forth in the SPD, so that the employee and/or a spouse may participant in a Health Savings Account as defined in Code Section 223. In addition, the Employer may designate Carryover amounts described in Part 9, Section 10 below as being subject to the limited-scope option of reimbursement under the Health FSA if the employee elects to contribute to the HSA or elects HSA-compatible coverage.
- (g) **Spousal Exclusion:** Employees may elect during the initial enrollment period and/or the annual enrollment period to exclude the spouse from coverage under the Health FSA, as set forth in the SPD, so that the spouse may participant in a Health Savings Account as defined in Code Section 223.

B. Dependent Care Assistance Plan

- (a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in your summary plan description).
- (b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: \$5000.00 for married filing jointly or single and \$2500.00 for married filing separately.
- (c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (a) above.
- (d) Minimum Contribution for the Benefit per Plan Year per Employee is \$0.00
- (e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as \$0.00

8. mySourceCard®

As part of the Plan, a mySourceCard™ is offered to you as an alternative reimbursement method as described in Part 8.

9. Grace Period & Run-Out

As indicated in Part 9, Sec. 9 below, the Employer has the option to adopt a grace period on any or all of your benefits. Please view this section to determine which, if any, of your benefits include this grace period.

If a grace period has been adopted and an HSA is one of the Benefit Package options offered under this Plan, the Employer will convert its general-purpose health FSA to an HSA-compatible option during the Grace Period for all health FSA participants.

- A limited-scope health FSA (that reimburses expenses only for preventive care and permitted coverage, such as dental and vision care).
- A post-deductible health FSA (that reimburses medical expenses only if they are incurred after the minimum annual deductible for the HDHP is met).

If a grace period has been adopted, it will begin on the first day of the next Plan Year and (depending on the benefit) will end up to two (2) months and fifteen (15) days later. To view a list of benefits and associated grace information, please see Part 9, Sec. 9.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible 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 Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Because Run-Out claims may be submitted after Grace Period claims, claims may be reordered to maximize reimbursement; as a result, grace claims and/or payments may be reassigned to the current plan year.

For example, assume that \$200 remains in your Health FSA account at the end of the 2014 Plan Year, and further assume that you have elected to allocate \$2400 to the Health FSA for the 2015 Plan Year. If you submit, for reimbursement, an Eligible Medical Expense of \$500 that was incurred on January 15, 2014, \$200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2014 Plan Year and the remaining \$300 will be paid out of amounts allocated to your Health FSA for 2015. Let us further assume that you then submit, for reimbursement, an Eligible Medical Expense of \$200 that was incurred on November 10, 2014. The amount that had been reimbursed using the \$200 from the 2005 Plan Year (grace money) would then be reordered to pay the November 10, 2014 claim, and the full

\$500 January 15, 2015 claim would then be reordered to be reimbursed from 2006 Plan Year money.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. The run-out period applies to claims, incurred both during the previous plan year and the grace period, that are reimbursable from the previous plan year. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period. To see a list of benefits and associated Run-Out information, see Part 9, Sec. 9.

You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

10. Benefit Grace and Run-Out Information

Benefit	Grace Adopted	Grace End Date	Grace Cap	Active Employee Run-Out Date	Terminated Employee / Coverage Run-Out Date / Days
FSA Dependent Care	No			90 days	03/31
FSA Medical	No			90 days	03/31

11. Carryover

If selected by your Employer in Part 9, Sec. 11 below, up to \$500 of the unused amount in a Health Care Account for a Plan Year (“Carryover Maximum”) may be rolled over for use in the entire, subsequent Plan Year.

With a Carryover, Health Care Account balances that are unused for a Plan Year may be used for reimbursement of Eligible Medical Expenses incurred at any time in the subsequent Plan Year (in addition to the amount that is otherwise available for reimbursement in the subsequent Plan Year)—not just during the first two (2) ½ months--subject to the following terms and conditions:

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year (“Carryover”).
 - For example, if you have an unused Health FSA balance at the end of the 2014 Plan Year equal to \$1000, and you have no other expenses that were incurred in 2014, your 2014 Carryover amount that may be used in the 2015 Plan Year is \$500. However, if you have 2014 Plan Year expenses equal to \$600 that you timely submit during the run out period for the 2014 Plan Year, then your 2014 Carryover amount that may be used in the 2015 Plan Year will only be \$400.

- If you incur an eligible expense during a Plan Year (“Current Year Expense”) but before the end of the prior Plan Year’s run out period, the Plan Administrator may, at its discretion, apply up to \$500 of the amount unused *at the end of the prior Plan Year* (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year (“Prior Year Expenses”) submitted during the prior Plan Year’s run out period and it will reduce the Carryover Maximum by the same amount.
 - For example, assume that you have \$800 at the end of the 2014 Plan year and you have elected \$2500 for the 2015 Plan Year. On February 1, 2015, you incur a \$2700 eligible medical expense. The entire \$2,700 expense will be reimbursed with the \$2,500 elected for 2015 and \$200 of the \$800 unused at the end of the 2014 Plan Year. However, only \$600 will be available for 2014 Plan Year expenses submitted during the run out period for the 2014 Plan Year and your 2014 Carryover Maximum is reduced to \$300 (\$500 maximum minus the \$200 already used). Further assume that after reimbursement of the \$2,700 expense that was incurred on February 1, 2015 but before the end of the run out period for the 2014 Plan Year, you submit a \$750 expense incurred in 2014. Only \$600 of that 2014 expense will be reimbursed and you will have no 2014 Carryover for use in the 2015 Plan Year.

- The Carryover does not count against the maximum salary reduction election identified in Part 9, Sec. 6 above.

- If you are otherwise eligible for the Health FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).

- Under IRS rules, if you have unused Health FSA amounts on the last day of a Plan Year in a general purpose Health FSA (i.e., anything other than a \$0 balance), you (and your spouse, if you are married) cannot contribute to an HSA during the following Plan Year. For this purpose, whether you have unused Health FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted).

However, if the Plan Administrator allows you to waive any Carryover eligibility before the last day of the Plan Year, or if you elect HSA compatible coverage for the following Plan Year and the Plan Administrator requires or allows you to direct the Carryover to a limited purpose Health FSA (if offered), then you will be eligible for the HSA in the following Plan Year (assuming that you elect a Carryover if not required).

- For example, assume that the Plan Administrator requires a carryover of unused amounts to the limited-scope option of reimbursement under the Health FSA if you elect HSA compatible medical coverage for the next plan year. Both FSAs allow you to carry over up to \$500. On December 31, 2014, you have \$600 unused in your general purpose Health FSA. For 2015, you elected HSA compatible medical coverage and decided to contribute \$2,500 to the limited purpose health FSA. On January 15, 2015, you incur a dental claim for \$2,700 (which can be paid by the limited purpose health FSA) and the plan pays you \$2,500, which is your total limited purpose health FSA election for 2015. On February 1, 2015, you submit and are reimbursed for \$300 in general medical expenses that you incurred on December 26, 2014, which reduces the unused amount in your 2014 general purpose health FSA from \$600 to \$300. As a result, \$300 from your 2014 general purpose health FSA is unused and will be carried over to your 2015 limited purpose health FSA at the end of the run out period for 2014. This carryover is then used to reimburse you for the \$200 left over from your January 15, 2015 dental claim, leaving \$100 that you can use for limited purpose health FSA expenses in 2015 or carryover to the next year.
- You must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

12. Health FSA Carryover and Run-Out Information

Carryover Adopted	Carryover Cap	Active Employee Run-Out Date	Terminated Employee / Coverage Run-Out Date / Days	Conversion to Limited-Scope Carryover Required if HSA-compatible coverage elected	Limited-Scope Carryover Permitted if Participant Elects before end of Plan Year
Yes	\$500.00	N/A	N/A	No	No

13. Qualified Reservist Distribution

The Employer has not adopted the Qualified Reservist Distribution.

13. Interaction with HRA.

See below regarding this Health FSA's rules with respect to coordination with an HRA:

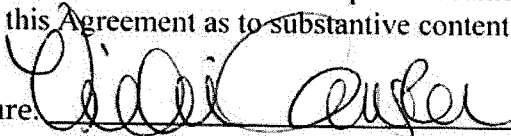
Does the Employer sponsor an HRA?	Yes
Does this Health FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health FSA?	FSA pays first

14. Method of Funding:

Flexible Spending Account Component benefits are paid from General Assets

15. Benefit Plan Option Documents

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content.

Signature 

Date: 1/27/16

Name: VICKI CANSLER
Title: CHRO

Executed at: Piedmont Healthcare, Inc
2727 Paces Ferry Road
Bldg 2, Suite 900
Atlanta, GA 30339

APPENDIX I

CLAIMS REVIEW PROCEDURE APPENDIX

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

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Service Provider must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

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

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Plan Service Provider and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from Plan Service Provider.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Plan Service Provider.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6: *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the

time period set forth in the first level appeal denial notice from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding your appeals:

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