Multnomah County

SUMMARY PLAN DESCRIPTION
Flexible Spending Account

Effective: 1/1/2022

With Third Party Administrative Services Provided By:

PacificSource ADMINISTRATORS

This document explains in detail the operation and rules that govern your Plan. Some features of a Flexible Spending Account described in this Summary Plan Description may not apply. Refer to Section II – Your Plan at a Glance to determine the specific features your Employer offers.

All participants must receive a copy of this Summary Plan Description. P00493
Print Date: 12/20/2021

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Multnomah County

SUMMARY PLAN DESCRIPTION
FLEXIBLE SPENDING ACCOUNT

I. Introduction

This Summary Plan Description (SPD) provides, in general terms, the main features of the Multnomah County Flexible Spending Account Plan (the "Plan") and the related Premium Payment Component, Health FSA Component and DCAP Component, how it can work for you, and how it can benefit you. Such plans are also known as cafeteria plans, or Section 125 plans.

Under the Plan, you may choose to redirect a portion of your wages to pay for certain benefits for you, your spouse, and your dependents with pre-tax dollars instead of after-tax dollars. Participating in the Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits. Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

You should read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a Participant. You should direct any questions you have to the Employer. A copy of your Plan Document is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. **IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL TAKE PRECEDENCE.**

The provisions of the Plan, as initially adopted or subsequently amended and restated, as the case may be, are effective 1/1/2022, through 12/31/2022. Your Plan's records are maintained on a fiscal period known as the Plan Year.

This SPD does not describe the Group Sponsored Insurance. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Group Sponsored Insurance plan documents.

Assistance in Other Languages
Plan Participants who do not speak English may contact PacificSource Administrator's Customer Service Department for assistance. PacificSource Administrators can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

II. Your Plan at a Glance

PERIOD OF COVERAGE and **PLAN YEAR** of this Plan: 1/1/2022 through 12/31/2022

Cafeteria Plan Name:	Multnomah County
Three Digit Plan Number:	
Type of Legal Entity:	Government Entity
Employer/Plan Sponsor:	Multnomah County 501 SE Hawthorne Blvd Suite 400 Portland, OR 97214
Benefits Coordinator:	Human Resources/Benefits Representative 503-988-7611
Legal Representative:	Multnomah County
Plan Administrator:	Multnomah County
Third Party Administrator:	PacificSource Administrators, Inc. PO Box 70168 Springfield, OR 97475 Phone: (800) 422-7038 FAX: (866) 446-6090
Secure Web Portal (TPA):	http://psa.consumer.pacificsource.com/
Claim Mailing Address (TPA):	PacificSource Administrators, Inc. PO Box 2797 Portland, OR 97208
Employer Representative or Named Fiduciary:	Multnomah County
The HIPAA Effective date:	1/1/2022
HIPAA Privacy Officer:	Multnomah County

BENEFIT PLANS: The administrative plan expenses are paid by the Employer.
The following components are offered under the Flexible Spending Account. You may elect:

- **Premium Payment Component:** Your salary reductions will be used to pay the premium for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 for you and your eligible family members.

- **Health FSA Component:** Your salary reductions will be deposited into a Health FSA Account from which funds will be withdrawn to reimburse you for eligible medical care expenses incurred by you and your eligible family members.
    - The election may be for:
        - **General-Purpose Health FSA (HRE) Option**
            - **Maximum Salary Reduction:** $2,750
            - **Minimum Salary Reduction:** $240
        - **Limited-Scope Health FSA (LSFSA) Option (Vision/Dental Care)**
            - **Maximum Salary Reduction:** Not Available
            - **Minimum Salary Reduction:** Not Available
        - **Limited-Purpose Health FSA (LFSA) Option (Vision/Dental/Preventive Care)**
            - **Maximum Salary Reduction:** Not Available
            - **Minimum Salary Reduction:** Not Available
    - **Mid-year Elections:** Mid-year hires and election changes due to a qualifying event, as allowed under the component, will not be pro-rated.
    - **Allows all applicable Change in Status options:** Both Increases and Decreases

- **DCAP Component:** Your salary reductions will be deposited into a Dependent Care Expense (DCE) Account from which funds will be withdrawn to reimburse you for eligible dependent care expenses.
    - **Maximum Salary Reduction:** $5,000 (legal maximum of $5,000; $2,500 for a married individual filing a separate return)
    - **Minimum Salary Reduction:** $0
    - **Mid-year Elections:** Mid-year hires and election changes due to a qualifying event, as allowed under the component, will not be pro-rated.
    - **Allows all applicable Change in Status options:** All of the events constituting a change in status under the regulations shall be allowed.

Funding Medium and Type of Plan Administration: The Health FSA Component is a group health plan. The Health FSA and DCAP Components are self-funded by the Employer and are contract administration plans. A third-party administrator processes claims for these components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these components. There is no trust for the Plan or any component.

Eligibility Requirements:

- Minimum of 20 hours required during each week

Entry Dates:

- First of the month following or coinciding with date of hire

Exclusions:

- On-call, temp (other than non-represented/mgt temps), independent contractors, interns

Deemed Elections: Under the Premium Payment Component you will be deemed to elect for each upcoming Plan Year whatever election is in effect in the current Plan Year, unless you expressly change your election by turning in a completed election materials prescribed by the Employer.

For example, if you are enrolled in the Premium Payment Component in the current year and want to remain enrolled in the upcoming year, you need not do anything, but if you want to stop participating in that Plan, you must affirmatively elect not to participate during the open enrollment period for the upcoming Plan Year. Under all the other components, you must make an affirmative election to participate every year by turning in a completed enrollment materials prescribed by the Employer or you will be deemed to have elected not to participate.

Election Changes: The election changes allowed under the Plan are those made effective by the IRS January 1, 2001. Any new election must be made and communicated in writing to the Employer within **60 days** of the change in status.

Carryover Provision: Carryover is permitted up to $550 on the Health FSA Component. You will be allowed to carryover unused amounts into the new Plan Year when you are a participant in the Health FSA Component as of the last day of the Plan Year, even if you do not make a new salary reduction in the new Plan Year.

Unused amounts in a Participant's HRE, LSFSA or LFSA Account may carry forward and remain available to reimburse eligible expenses incurred in later years.

- Under the Health FSA Component, when the Carryover Provision is permitted and unused amounts are carried forward, you will be deemed as having "elected for each upcoming Plan Year".

Grace Period: Your Employer does not offer a Grace Period on the FSA Component(s).

Forfeitures: Unclaimed cash balances are forfeited to the Employer after the end of a Plan Year. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the Plan during the Plan Year or may be retained by the Employer to be used in the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. Cash balances forfeited to the Employer cannot be returned directly to the individual Participant(s) who forfeited those funds.

Claim Reimbursement Forms may be submitted the following ways:

- Electronically via our secure web portal: https://psa.consumer.pacificsource.com/
- Faxed to (866) 446-6090
- Mailed to PO Box 2797, Portland, OR 97208

Claim Submission Period Ends: 90 days after the close of the Plan period of coverage (also known as a run-out period)

Debit Card Availability: Health FSA and Transit

Documentation needed for claim submission: Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense, the date of service, and the amount of your expense. Note: In some instances, a statement from the provider that a medical care expense is medically necessary may be required.

Participation Rules:

- Reimbursements of Health FSA expenses include the period of coverage if such expenses are otherwise eligible healthcare expenses under the Code.
    - If you terminate employment, your FSA participation ends on the date of their final paycheck.
    - If you experience a loss of eligibility, your FSA participation ends on the paycheck date of their final contribution.
- Reimbursements of DCAP expenses include the period of coverage and/or following termination - that is, through the remainder of the Plan Year if such expenses are otherwise eligible expenses under the Code.

Coverage continuation (if applicable): If you lose coverage under the Health FSA Component as a result a qualifying event (i.e. termination of employment or cessation of eligibility because of a reduction in hours of employment) you may be entitled to elect coverage continuation under the Health FSA to the extent required by federal law. See Section IV Component Options – Health FSA Component for more information.

A Participant cannot be forced to repay or voluntarily repay the employer for any amounts exceeding his or her Health FSA account balance (under most circumstances, individuals who have overspent their accounts will not elect continued coverage). The plan cannot accept the additional contributions as such a practice would be a violation of the Uniform Coverage rule.

Treatment of Rehires and/or Treatment of Participants that regain eligibility: If you terminate employment and later are rehired or lose eligibility and later regain eligibility during the same Plan Year, you may be entitled to rejoin the plan based on your Employer's plan design.

See Section III Participation in the Plan for more information regarding the treatment of rehires and treatment of Participants that regain eligibility during the same Plan Year.

Continuing Plan Participation under FMLA: Per Federal Law, coverage may continue under the provisions of Family Medical Leave Act (FMLA). If applicable, the option for member payment of continuation is listed below:

- FMLA coverage is offered and paid by the Employee based on the following: Pay-as-you-go with after-tax dollars, Pre-pay with pre-tax dollars, or Catch-up method. Upon return to work, you must complete new enrollment materials to resume participation

III. Participation in the Plan

✓ ***Who can participate in the Plan?***

Employees who actually participate in the Plan are called "Participants". You are eligible to participate if you have met the following required eligibility standards and waiting period as indicated below:

- Minimum of 20 hours required during each week

Your "entry date" is the date on which you become eligible to participate in the Plan as indicated below:

- First of the month following or coinciding with date of hire

Eligibility for the Health FSA Component is subject to the eligibility for the Medical Insurance Plan.

- Individuals eligible to enroll in the Medical Insurance may enroll in a General-Purpose Health FSA (regardless of whether coverage under the Medical Insurance Plan is elected), covering all healthcare expenses as defined in Code §213(d).
- Individuals not eligible to enroll in the Medical Insurance may enroll in a Limited-Scope Health FSA, limited to covering Vision and Dental Care.
- Individuals who elect to participate in an HSA Benefit, or a Spouse participating in their Employer's HSA Benefit, may only enroll in a Limited-Purpose Health FSA, limited to covering Vision, Dental and Preventive Care.

Eligibility for the Group Sponsored Insurance is also subject to the additional eligibility requirements, if any, specified in the insurance plan documents.

✓ ***Are there any Employees who are not eligible to participate in the Plan?***

An "Employee" is an individual that the Employer classifies as a common-law Employee and who receives Compensation from the Employer. Employees do not, however, include (a) individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as a common-law employee; (b) individuals who perform services for the Employer but who are paid by a temporary or other employment or staffing agency; or (c) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

The following Employees are excluded from participating in the Plan:

- On-call, temp (other than non-represented/mgt temps), independent contractors, interns

✓ ***What must I do to enroll?***

When you first meet the eligibility requirements of the Plan, you must complete enrollment materials (or completing electronic enrollment materials) prior to your entry date. The enrollment materials must be submitted to the Employer before the first day of the pay period in which participation will begin. After the initial period of coverage, you may renew your participation for the next Plan Year by filing your elections with your Employer during the next open enrollment period.

Failure to make an election will be treated as electing to not participate in the Plan unless an event occurs that would justify a mid-year election change, as described in Section V Administrative Provisions – Election Changes.

✓ ***When does participation end?***

The date your participation will cease under the Plan varies from component to component. Under the various components described in Section IV Component Options, your participation in each component will, unless otherwise expressly stated, cease on the date you terminate employment or otherwise cease to be eligible under the Plan or otherwise cease to be an eligible Employee.

- Upon termination, FSA participation ends on the date of their final paycheck.
- Upon loss of eligibility, FSA participation ends on the paycheck date of their final contribution.

✓ ***What if I terminate and I am rehired during the Plan Year?***

If you enroll in the Health FSA Component, terminate employment, and are later rehired within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation; resuming your per pay period contribution. If a period of non-coverage occurs due to missed contributions, services incurred during the period of non-coverage will not be eligible for reimbursement and missed contributions cannot be made up. Enrollment materials must be received within 31 days of your rehire date. If you are rehired more than 30 days after termination, you may immediately rejoin the Plan and make a new benefit election. The new election is subject to the IRS annual max and plan design if less. Services incurred during the period of non-coverage will not be eligible for reimbursement. Any unused reimbursement account balance prior to initial termination of participation will have a separate eligibility period. Enrollment materials must be received within 31 days of your rehire date.

If you enroll in the DCAP Component, terminate employment, and are later rehired within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation less any missed contributions; resuming your per pay period contribution. Qualifying services incurred during the period of termination would be eligible for reimbursement through the end of the Plan Year but missed contributions cannot be made up. Enrollment materials must be received within 31 days of your rehire date. If you are rehired more than 30 days after termination, you may immediately rejoin the Plan and make a new benefit election. The new election is subject to the IRS annual max and plan design if less. Qualifying services incurred during the period of termination would be eligible for reimbursement through the end of the Plan Year. Enrollment materials must be received within 31 days of your rehire date.

✓ ***What if I lose eligibility and then later regain eligibility during the Plan Year?***

If you enroll in the Health FSA Component, lose eligibility, and later regain eligibility within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation; resuming your per pay period contribution. If a period of non-coverage occurs due to missed contributions, services incurred during the period of non-coverage will not be eligible for reimbursement and missed contributions cannot be made up. Enrollment materials must be received within 31 days of the date you regain eligibility. If you regain eligibility more than 30 days after the loss of eligibility date, you may immediately rejoin the Plan and may make new benefit elections. The new election is subject to the IRS annual max and plan design if less. Services incurred during the period of non-coverage will not be eligible for reimbursement. Any unused reimbursement account balance prior to initial termination of participation will have a separate eligibility period. Enrollment materials must be received within 31 days of the date you regain eligibility.

If you enroll in the DCAP Component, lose eligibility, and later regain eligibility within 30 days,

you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation less any missed contributions; resuming your per pay period contribution. Qualifying services incurred during the loss of eligibility period would be eligible for reimbursement through the end of the Plan Year but missed contributions cannot be made up. Enrollment materials must be received within 31 days of the date you regain eligibility. If you regain eligibility more than 30 days after the loss of eligibility date, you may immediately rejoin the Plan and make a new benefit election. Qualifying services incurred during the loss of eligibility period would be eligible for reimbursement through the end of the Plan Year. Enrollment materials must be received within 31 days of the date you regain eligibility.

All Employees who terminate and are later rehired or lose eligibility and later regain eligibility during the same Plan Year must be treated the same based on when the event occurs.

- If you are rehired or regain eligibility within the same Plan Year as you termed or lost eligibility, but there is not enough time left in the Plan Year to meet the rehire or regain eligibility rules, you are still required to complete the remaining timeframe of the rehire or regain eligibility rules before entering the new FSA Plan Year.
- If you are rehired or regain eligibility and also experience an intervening event that would permit an election change (as permitted under the Plan), the rehire or regain eligibility rules would be applied first and the election change would follow.
- If you are not rehired or don't regain eligibility within the same Plan Year that you terminated or lost eligibility, you will be treated as a new hire and must meet the eligibility and entry requirements based on your Employer's FSA plan design.

If prior to termination or loss of eligibility, you were eligible and choose to waive FSA participation, your Employer's plan design for rehire and regain eligibility will still apply and will define whether you may make a new election or will be reinstated back to your previous enrollment status of no election. Refer to the above stated rules for guidance.

IV. Component Options

Premium Payment Component

✓ ***What is the Premium Payment Component?***

You will be able to pay for your share of contributions for Group Sponsored Insurance premiums or other qualified benefits with pre-tax dollars, provided you elect this coverage on the applicable enrollment materials. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. In some situations your Employer may fund a portion of the premium.

Eligible Group Sponsored Insurance premiums include the premiums paid for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 made available by the Employer. The insurance may cover you, your spouse, and/or any eligible dependent children. You may not enroll for this benefit if you can be reimbursed for the premium cost by any other source.

If a Health Savings Account (HSA) is offered by your Employer and you elect to participate, eligible Participants may make contributions to the HSA on a pre-tax basis from which funds can be withdrawn to pay for eligible healthcare expenses. Your Employer does not offers a Health Savings Account (HSA) Benefit under the Plan.

✓ ***How are my benefits paid for under the Premium Payment Component?***

If you select Group Sponsored Insurance described above, then you may be required to pay a portion of the contributions. When you complete the enrollment materials, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Employer). The Employer may contribute all, some, or no portion of the benefits under the Premium Payment Component that you have selected, as described in documents furnished separately to you.

The Employer will then disburse the premium payment(s) to the applicable carrier(s). This method of payment is sometimes referred to as “Employer Disbursed Premium” (EDP) payments.

Note: This SPD does not describe the Group Sponsored Insurance. Consult the Group Sponsored Insurance plan documents and the separate SPD for the Group Sponsored Insurance.

Health FSA Component

✓ ***What is the Health FSA Component?***

You may use a Health FSA to pay for eligible medical care expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary, provided you elect this coverage on the applicable enrollment materials. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The Health FSA Component is intended to pay benefits solely for medical care expenses not reimbursed elsewhere. Accordingly, the Health FSA Component shall not be considered to be a group health plan for coordination of benefits purposes, and benefits under the Health FSA Component shall not be taken into account when determining benefits payable under any other plan. In the event that an expense is eligible for reimbursement under both the Health FSA Component and an HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

✓ ***What are my Health FSA Component options?***

A Health FSA Component election may be for one of the following:

(a) General-Purpose Health FSA Option;
(b) Limited-Scope Health FSA Option (Vision/Dental Care, excluding Preventive Care); or
(c) Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care).

Refer to Section II – Your Plan at a Glance to determine the options available to you under your Employers' Plan.

HSA Benefits cannot be elected with the Health FSA Component unless the Limited-Purpose Health FSA Option is available and selected. In addition, when the Employer offers the Carryover Provision, and a Participant is reported as participating in an HSA Benefit, any unused amounts remaining in the Participant's General-Purpose Health FSA at the end of the preceding Plan Year that are available for carryover, if any, will be carried over to a Limited-Purpose Health FSA.

✓ ***What are my Health FSA accounts?***

Once you elect to participate in one of the Health FSA Component options, then an account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you elected to have reduced from your salary or wages. Your Health FSA accounts are recordkeeping accounts and do not bear interest.

Your salary reductions will be deposited into a Health Related Expense (HRE) Account, a Limited-Scope Health FSA (LSFSA) Account or a Limited-Purpose Health FSA (LFSA) Account from which funds will be withdrawn to reimburse you for eligible medical care expenses incurred by you and your eligible family members under one of the Health FSA Component options.

✓ ***What are the benefits that I may elect under the Health FSA Component?***

The maximum salary reduction you can elect under the General-Purpose Health FSA Option is $2,750 with a minimum salary reduction of $240. The maximum salary reduction you can elect under the Limited-Scope Health FSA Option is with a minimum salary reduction of . The maximum salary reduction you can elect under the Limited-Purpose Health FSA Option is with

a minimum salary reduction of . Mid-year hires and election changes due to a qualifying event, as allowed under the component, will not be pro-rated.

✓ ***How are my benefits paid for under the Health FSA Component?***

When you complete the enrollment materials, you specify the amount of benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer). For example, suppose you have elected a salary reduction of $1,300 for medical care expenses and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then your Account would be credited with a total of $1,300 during the Plan Year. If you are paid bi-weekly, then your Account would reflect that you have paid $50.00 ($1,300 divided by 26) each pay period in contributions for the benefits that you have elected.

✓ ***What medical care expenses may be reimbursed?***

The Health FSA Component cannot reimburse you for any expenses that have been reimbursed by any other plan or source and you cannot claim a tax deduction for any expenses reimbursed under the Plan. The eligible medical care expenses vary according to the type of Health FSA Component option that is elected, as described below.

(a) **General-Purpose Health FSA Option.** For purposes of this Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d). Over-the-counter (OTC) medicines or drugs such as aspirin, antihistamines, and cough syrup qualify as medical care expenses. In addition, as described above, only reasonable quantities of OTC drugs will be reimbursed from your HRE Account in a single calendar month. Stockpiling is not permitted.

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of medical care under Code §213(d) and other requirements for reimbursement under the Health FSA.

EXCLUSIONS:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.

- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code §213(d).
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. §1.125-5(k)(4) or other applicable law or regulations.

For more information about what items are-and are not-medical care expenses, consult IRS Publication 502 (Medical and Dental Expenses) under the headings "What Medical Expenses Are Includible?" and "What Expenses Are Not Includible?" But use IRS Publication 502 with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some statements in IRS Publication 502 aren't correct when determining whether that same expense is reimbursable from a Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code §213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from a Health FSA. And not all expenses that are reimbursable under a Health FSA are deductible. For example, Health FSAs may reimburse OTC drugs if they qualify as medical care under Code §213(d), but they are still not deductible under Code §§213(a) and 213(b).

Ask the Employer or PSA if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Employer and PSA are not providing legal advice.

(b) **Limited-Scope Health FSA Option (Vision/Dental Care, excluding Preventive Care).** You may be eligible to make/receive tax-favored contributions to the Limited-Scope Health FSA Option and participate in a Health FSA Component if the Health FSA reimbursement is limited to the medical care expenses listed below:
- Services or treatments for dental care (excluding premiums); or
- Services or treatments for vision care (excluding premiums).

(c) **Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care).** The Limited-Purpose Health FSA will not reimburse medical care expenses that would disqualify an individual from contributing to an HSA. According to rules in Code §223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical care expenses as described under the General-Purpose Health FSA Option (see subsection (a) above). You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA Component if the Health FSA reimbursement is limited to the medical care expenses listed below:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums); or
- Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code §223(c)(2)(C). This may include prescribed drugs to the extent that such drugs are taken by an eligible individual (1) 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); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) 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.

✓ ***What is the Carryover Provision?***

See Section II Your Plan at a Glance for details on the carryover of account balance, if any, available under the Health FSA Component.

If the Carryover Provision is not permitted, any unused amounts in a Participant's HRE, LSFSA, or LFSA Account at the end of a coverage period will be forfeited per the current Treasury Regulation "Use-it-or-Lose-it" rule as discussed in Section V Administrative Provisions – "Use-it-or-Lose-it" Rule.

If the Carryover Provision is permitted, unused amounts in a Participant's HRE, LSFSA, or LFSA Account will carry forward and remain available to reimburse eligible medical care expenses incurred in later years. The amount allowed to carryover is subject to a maximum dollar which could prevent a carryover of all unused amounts. Amounts over this maximum will be subject to forfeiture per the current Treasury regulation "Use-it-or-Lose-it" rule as discussed in Section V Administrative Provisions.

You will be allowed to carryover unused amounts into the new Plan Year when you are a participant in the Health FSA Component as of the last day of the Plan Year, even if you do not make a new salary reduction in the new Plan Year.Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless coverage is continued (see Section IV Component Options - Health FSA Component, *"Can I continue my Health FSA coverage after terminating employment?"*).

Under IRS rules, if you carry over any unused Health FSA amounts to a General-Purpose Health FSA, you (and any other individual whose expenses can be reimbursed by your Health FSA) cannot contribute to an HSA during the entire next Plan Year. Thus, if you have unused amounts remaining in a General-Purpose Health FSA at the end of a Plan Year that are available for carryover and you elect to participate in an HSA benefit for the next Plan Year, the unused amounts will be carried over to a Limited-Purpose Health FSA when available. However, you may continue to submit claims for General-Purpose expenses incurred during the

preceding Plan Year until the end of the run-out period of the following Plan Year, to be reimbursed from your available Health FSA amounts for the preceding Plan Year. Otherwise, if you (or someone else whose expenses can be reimbursed by your Health FSA) would like to contribute to an HSA during the next Plan Year, you must waive (decline) the carryover before that Plan Year begins, using materials available from the Employer. If you waive the carryover, you may continue to submit claims for expenses incurred during the preceding Plan Year until the end of the run-out period of the following Plan Year, to be reimbursed from your available General-Purpose Health FSA amounts. If those claims do not use up your entire Health FSA balance for the preceding Plan Year, any unused amounts will be forfeited in accordance with your waiver.

✓ ***What amounts will be available from the HRE, LSFSA, or LFSA Account at any particular time during the Plan Year?***

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying medical care expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). This is known as the "Uniform Coverage" rule. During the run-out period, carryover amounts may be available either for prior-year or current-year claims.

✓ ***Is there any risk of losing or forfeiting the amounts that I elect?***

Yes. The difference between what you elected (increased by any carryovers from the previous Plan Year, if applicable) and the medical care expenses that were reimbursed will be forfeited at the end of the time limits. You should read the Plan in its entirety before electing to participate in the Plan.

✓ ***Does COBRA apply to my Health FSA?***

Health FSA COBRA continuation coverage will be available if the Employer normally employed 20 or more Employees on a typical business day during 50% or more of the preceding calendar year. The COBRA Administrator shall provide notice to the Participant of his or her right to continuation coverage and shall administer continuation coverage hereunder in accordance with applicable law and regulations.

Employers subject to COBRA must offer Health FSA COBRA coverage to qualified beneficiaries who lose their Health FSA coverage as the result of a qualifying event when the account is underspent (taking into account all claims submitted and deductions due before the date of the qualifying event). An Employer is not required to offer COBRA when accounts are overspent, but may choose to do so in a uniform manner.

The type of COBRA continuation obligation depends on whether the Health FSA is considered to be a qualifying Health FSA.

- If the Health FSA is a qualifying Health FSA, COBRA continuation coverage must be offered to all qualified beneficiaries but is subject to special limitations. This is called Special Limited COBRA continuation. If the Special Limited COBRA continuation is elected for the Health FSA, it will be available only for the Plan Year in which the qualifying event occurs, with coverage for the Health FSA ceasing at the end of the Plan Year, and no ability to re-enroll with a new election for the next Plan Year. In the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may not be extended.
- If the Health FSA is not a qualifying Health FSA, COBRA continuation coverage must be offered to all qualified beneficiaries for the maximum COBRA period which includes the

rest of the Plan Year in which the qualifying event occurred, and, until the maximum COBRA period expires. Qualified beneficiaries may re-enroll for subsequent plan years during open enrollment with a new election. In addition, in the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may be extended.

Regardless if the Health FSA is considered qualifying or not, if the Carryover Provision applies to the Health FSA, the Carryover Provision would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year. Although the Carryover Provision would not last beyond the end of the 18-month or other applicable maximum COBRA coverage period.

A Participant who elects Health FSA COBRA continuation coverage will generally pay for coverage with after-tax dollars by writing a check to his or her Employer each month. However, an agreement can be made with the Employer to make payments with pre-tax dollars to his or her Employer, generally on a monthly basis but only through the end of the Plan Year in which the qualifying event occurred.

✓ ***Can I continue my Health FSA coverage without electing COBRA?***

No. Refer to Section III Participation in the Plan, "When does participation end?" This agreement is referred to as a Premium Completion Agreement. In the event the Employee terminates employment or otherwise ceases to be an eligible Employee, then the Employer can require the Employee to waive his or her COBRA rights with respect to the Health FSA as a condition to electing the voluntary Premium Completion Agreement to cover the Health FSA premium for the balance for the current Plan Year.

If the Carryover Provision applies to the Health FSA, the Carryover Provision would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year, although the Carryover Provision would not last beyond the end of the coverage period that it rolled into.

DCAP Component

✓ ***What is the DCAP Component?***

You may use the DCAP Component to pay for eligible dependent care expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary, provided you elect this coverage on the applicable enrollment materials. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The DCAP Component is intended to pay benefits solely for dependent care expenses not reimbursed elsewhere. Eligible dependent expenses might include: infant care, daycare, elder care etc. You may receive reimbursements under this component only if the dependent care is necessary to enable you and your spouse to work or seek employment, or if you work and your spouse is a student or is disabled. The dependent must reside with you more than half the year for the expenses with respect to that dependent to be eligible for reimbursement under this portion of the DCAP Component.

✓ ***What is my DCE Account?***

Once you elect to participate in the DCAP Component, then an account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you elected to have reduced from your salary or wages. The account is a recordkeeping account and does not bear interest.

Your salary reductions will be deposited into a Dependent Care Expense (DCE) Account from which funds will be withdrawn to reimburse you for eligible dependent care expenses incurred by you.

✓ ***What are the benefits that I may elect under the DCAP Component?***

The maximum salary reduction you can elect under the DCAP Component is $5,000 with a minimum salary reduction of $0. Mid-year hires and election changes due to a qualifying event, as allowed under the component, will not be pro-rated.

The amount of dependent care expense reimbursement that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code §129 when your election is made. The $5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining the household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of the household; or
- you are single or the head of the household for federal income tax purposes.

If you are married and file a separate federal income tax return under circumstances other than those described above, then the maximum DCAP benefit that you may exclude from your income under Code §129 is $2,500 for a calendar year.

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

✓ ***How are my benefits paid for under the DCAP Component?***

When you complete the enrollment materials, you specify the amount of DCAP benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer). For example, suppose you have elected a salary reduction of $2,600 for dependent care expenses and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then your DCE Account would be credited with a total of $2,600 during the Plan Year. If you are paid bi-weekly, then your DCE Account would reflect that you have paid $100.00 ($2,600 divided by 26) each pay period in contributions for the benefits that you have elected.

✓ ***What dependent care expenses may be reimbursed?***

Dependent care expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a qualifying individual, as defined below. All of the following conditions must be met for such expenses to qualify as dependent care expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a qualifying individual, that is, he or she must be:
    - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
    - your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
    - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

  NOTE: Under a special rule for children of divorced or separated parents, a child is a qualifying individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Employer for more information on which individuals will qualify as your qualifying individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCE Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your spouse is not working or looking for work when the expenses are

incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.

- The expenses are incurred for the care of a qualifying individual or for household services attributable in part to the care of a qualifying individual.
- If the expenses are incurred for services outside of your household for the care of a qualifying individual other than a person under age 13 who is your qualifying child, then the qualifying individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person for whom you (or your spouse) are entitled to a personal exemption under Code §151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the qualifying individual stays overnight.
- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):
    - expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);
    - the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
    - expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided-e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

For more information about what items are-and are not-deductible dependent care expenses, consult IRS Publication 503 (Child and Dependent Care Expenses) under the heading "Tests to Claim the Credit." But use Publication 503 with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code §21 (the Dependent Care Tax Credit, discussed below), not to explain what is reimbursable under a DCAP. In fact, some of the statements in Publication 503 aren't correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit and what expenses are reimbursable under a DCAP. Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought.

Ask the Employer or PSA if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Employer and PSA are not providing legal advice.

✓ ***What amounts will be available from the DCE Account at any particular time during the Plan Year?***

The amount of coverage that is available for reimbursement of qualifying dependent care expenses at any particular time during the Plan Year will be equal to the amount credited to your DCE Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. For example, suppose that you incur $1,500 of dependent care expenses. At that time, your DCE Account would only have been credited with $700 ($100 times 7 pay periods), so only $700 would be available for reimbursement (assuming that you had not received any prior reimbursements). The remaining $800 in dependent care expenses would be held as a pending claim until additional contributions are credited to your DCE Account.

✓ ***Is there any risk of losing or forfeiting the amounts that I elect?***

Yes. The difference between what you elected and the dependent care expenses that were reimbursed will be forfeited at the end of the time limits. You should read the Plan in its entirety before electing to participate in the Plan.

✓ ***Can I continue DCAP coverage after terminating employment?***

When you cease to be a Participant under the DCAP Component, your salary reductions and election to participate will terminate. However, you will be able to receive reimbursements for qualifying dependent care expenses incurred during the period of coverage following termination through the end of the Plan Year.

V. Administrative Provisions

Funding and Type of Plan Administration

The Employer is the Plan Administrator for the Plan in accordance with ERISA §3(16)(a). The Plan is intended to qualify as a "cafeteria plan" under Code §125. The Employer's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan.

The Employer has retained PacificSource Administrators, Inc. (PSA) to act as the Third Party Administrator and provide certain administrative services associated with the Plan. PSA is not a fiduciary of the Plan. PSA has **no** discretionary authority to interpret the Plan provisions or issues arising under the Plan, such as issues of eligibility, coverage, and benefits. PSA is not an "administrator" as defined in ERISA §3(16)(a).

Nothing herein will be construed to require the Employer or PSA to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid. While the Employer has complete responsibility for the payment of benefits out of its general assets (except for Premium Payment benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make benefit payments on its behalf.

You must make all elections about the use of the Plan before your entry date into the Plan. If you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Employer). The amount reduced from your salary or wages cannot exceed the amount of your annual salary or wages.

Only expenses incurred on or after your entry date and prior to the end of the Plans period of coverage are eligible for payment. Your period of coverage is generally the same as the Plans period of coverage but if you begin or end eligibility in the middle of the Plan Year, your period of coverage is the portion of the Plan Year during which you were eligible in the Plan. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid. You may submit claims incurred during your "period of coverage" for 90 days after the Plans period of coverage. Claims submitted beyond this run-out period are ineligible for reimbursement.

For purposes of the Group Sponsored Insurance, the terms Spouse and Dependent are defined as provided in the Group Sponsored Insurance. For purposes of the other benefits, Spouse means a person of the same or opposite sex who is treated as a spouse for federal tax purposes. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 (e.g. end of the year in which the child turns 26) as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's

definition. See the Employer for more information about which individuals will qualify as your Spouse or Dependents.

You and individuals who qualify as your dependents may receive benefits under the Plan. An individual may qualify as your dependent for purposes of this Plan even if that individual is not your tax dependent. An individual who would qualify as your tax dependent but has gross income in excess of the exemption amount, is a dependent of a dependent, or is married and files a joint tax return with his or her spouse, will be considered your dependent for purposes of this Plan. This may include the Participant's children, grandchildren, stepchildren, parents, in-laws, or any other person (other than the Participant's spouse) whose principal place of abode is the home of the Participant and who is a member of the Participant's household. For purposes of the DCAP Component, a dependent must reside with you for more than half of the year for expenses with respect to that dependent to be eligible for reimbursement under that portion of the Plan.

Election Changes

✓ ***Can I change my elections under the Plan during the Plan Year?***

As a general rule, your elections for the Plan Year are irrevocable for the balance of the year. However, certain exceptions apply which may allow you to revoke your election and make a new election. 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 Employer, in its sole discretion and on a uniform and consistent basis, 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.

Accounts subject to the Uniform Coverage rule (Health FSA) can be excluded. Specific to your Plan design, benefit changes can be made as indicated below:

- Increases and Decreases to the Group Sponsored Insurance premiums (if permitted by insurance carrier) shall automatically result in a corresponding election change to the Premium Payment Component
- Both Increases and Decreases can be permitted to the HRE, LSFSA, or LFSA Account
- Both Increases and Decreases can be permitted to the DCE Account

If the Plan allows you to make reductions to your Health FSA coverage, your reduction cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute $100 per month to the Health FSA and in the second month you were reimbursed for expenses in the amount of $700. If a change in status event occurs in the third month that allows you to change coverage, your future contributions to the Health FSA cannot be reduced to a point where the total contributions for the Plan Year are less than the $700 already reimbursed for the Plan Year.

✓ ***When can I change my elections under the Plan during the Plan Year?***

If any change in election event occurs, you must inform the Employer and request a status change within 60 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage

under the Medical Insurance Plan). If the change involves a loss of your spouse's or dependent's eligibility for medical insurance benefits, then changes made to your Group Sponsored Insurance Plan will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 60 days.

- **Leaves of Absence (Applies to all Components of this Plan).** You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Section V Administrative Provisions – Family and Medical Leave Act.

- **A Change in Status (Applies to all Components as Limited Below).** The Plan allows you to make a mid-year plan change or revocation of a benefit election if the change or revocation is consistent with a change in status. In this regard, a change in status is any of the following:
    - An event that changes your legal marital status, including marriage, death of a Spouse, legal separation, or annulment;

    - An event that changes the number of your Dependents, including by reason of birth, adoption, placement for adoption, or death of a Dependent;

    - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, 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 full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

    - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or

    - A change in your, your Spouse's, or your Dependent's place of residence.

- **Change in Status-Other Requirements (Applies to Premium Payment, Health FSA (as limited below) and DCAP Components).** Generally, a revocation or change of your election is consistent with a change in status only if it is on account of and corresponds to a change in status that affects eligibility under an Employer's benefit plan. For example, if your Spouse terminates employment and loses healthcare coverage under the former Employer's benefit plan as a result, then that is a change in status affecting eligibility for healthcare coverage; if you then add your Spouse under the Employer's benefit plan, you could modify your election under the Premium Payment Component to pay for the increase in premiums under this Plan. An election change under the DCAP Component is consistent with a change in status if the election change is on account of and corresponds with a change in status that affects dependent care expenses.

  In addition, you must satisfy the following specific requirements in order to alter your election based on that change in status:
    - **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** A special

rule governs which types of election changes are consistent with the change in status. If you, your spouse, or dependent gains or loses coverage due to a COBRA qualifying event, you may change your election under the Premium Payment Component and Health FSA Component to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage. See your Employer for more information.

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 any of the following: no medical 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 revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a change in status. An election to cancel medical 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.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** For a change in status in which you, your Spouse, or your Dependent gains 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.

- **DCAP Component.** With respect to the DCAP Component, you may change or terminate your election with respect to a change in status event only if (a) such change or termination is made on account of and conforms with a change in status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a change in status that affects the eligibility of dependent care 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 DCAP 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 DCAP. This event constitutes a change in status. Mike's election to cancel coverage under the DCAP would be consistent with this change in status.

- **Special Enrollment Rights (Applies Only to Premium Payment Component for the Medical Insurance Plan).** In certain circumstances, enrollment for Medical Insurance

Benefits may occur outside the Open Enrollment Period. The Employer's Special Enrollment Notice also contains important information about your special enrollment rights. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under this Plan to correspond with the special enrollment right set forth in Section 9801(f) of the Internal Revenue Code. In brief, those rights provide that if you lose other healthcare plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, you may be able to change your healthcare plan elections and make a corresponding change to your elections under this Plan. If you would like to do so, you should contact the Employer as soon as possible after the event occurs, within 60 days of that event.

- **Certain Judgments, Decrees, and Orders (Applies to Premium Payment and Health FSA Components, but Not to DCAP Component).** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Group Sponsored Insurance or Health FSA, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

- **Medicare and Medicaid (Applies to Premium Payment and Health FSA Components as Limited Below, but Not to DCAP Component).** If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Group Sponsored Insurance and/or your Health FSA may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Group Sponsored Insurance and/or your Health FSA, as applicable).

- **Change in Cost (Applies to Premium Payment and DCAP Components as Limited Below, but Not to Health FSA Component).** If the cost charged to you for your Group Sponsored Insurance or dependent care expenses significantly increases during the Plan Year, then you may choose to do any of the following:

    - make a corresponding increase in your contributions;

    - revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;

    - drop your coverage, but only if no other benefit package option provides similar coverage.

  For these purposes, the Health FSA is not similar coverage with respect to the Group Sponsored Insurance; an HMO and a PPO are considered to be similar coverage; and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage. If the cost of Group Sponsored Insurance or dependent care expenses significantly decreases during the Plan Year, then the Employer may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;

- if you are enrolled in another benefit package option, you may change your election on a prospective basis to elect the benefit package option that has decreased in cost; or

- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Employer will automatically adjust your election contributions to reflect the minor change in cost.

The Employer generally will notify you of increases or decreases in the cost of Group Sponsored Insurance; you must notify the Employer of increases or decreases in the cost of dependent care expenses if you want to make changes. The change in cost provision applies to DCAP Component only if the cost change is imposed by a dependent care provider who is not your relative.

- **Change in Coverage (Applies to Premium Payment and DCAP Components, but Not to Health FSA Component).**
  You may also change your election if one of the following events occurs:

  - **Significant Curtailment of Coverage.** If your Group Sponsored Insurance or DCAP coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Group Sponsored Insurance or DCAP coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Employer generally will notify you of significant curtailments in Group Sponsored Insurance; you must notify the Employer of significant curtailments in DCAP coverage if you want to make changes.)

  - **Addition or Significant Improvement of Salary Reduction Plan Option.** If the Plan adds a new option or significantly improves an existing option, then the Employer may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Employer may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

  - **Loss of Other Group Health Coverage.** You may change your election to add

group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- **Change in Election Under Another Employer Plan.** 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 a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under this Plan to replace the dropped coverage.

- **DCAP Coverage Changes.** You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

- **Mid-Year Election Changes for Health Coverage (Applies only to Premium Payment Component)**
  Employer will default to not allow Employees to revoke their election under their Premium Payment Component if they meet the conditions specified under "Reduction in hours in service" or "Enrollment in a Qualified Health Plan".

✓ **Other than the reasons above, when could my elections change?**

You may also change your election if one of the following events occurs:

- **Error at time of Enrollment.** If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Employer shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Employer may include withholding of any amounts due from your compensation.

- **Highly Compensated and/or a Key Employee.** If you are a Highly Compensated Employee or a Key Employee as defined by the IRS, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Congress has intended this Plan to be available to all classes of Employees and not to be considered top-heavy in participation.

  Plan experience will dictate whether contribution limitations on Highly Compensated or

Key Employees will apply. Employees will be notified of these limitations if affected. Your Employer may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a Highly Compensated and/or Key Employee as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Family and Medical Leave Act
(if applicable)

✓ ***What is the Impact of the Family and Medical Leave Act (FMLA)?***

Notwithstanding any other provision in this Plan, the Employer may (a) permit you to revoke (and subsequently reinstate) your election of one or more benefit coverage's under the Plan, (b) adjust your compensation reduction as a result of a revocation or reinstatement and (c) permit payment of your share of the cost of benefit coverage during an unpaid leave with after-tax dollars (or pay for benefits under another arrangement such as pre-paying the benefits with pre-tax dollars prior to the leave or "catching up" by paying for the benefits with pre-tax dollars subsequent to the leave) to the extent the Employer deems necessary or appropriate to assure the Plan's compliance with the provisions of the FMLA and any regulation pertaining thereto. You should consult the Employer if you have any questions.

✓ ***How does a leave of absence (such as FMLA) affect my health benefits?***

***FMLA Leaves of Absence*.** If you go on a qualifying leave under the FMLA, then to the extent required by the FMLA your Employer will continue to maintain your Group Sponsored Insurance and Health FSA coverage on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Group Sponsored Insurance and Health FSA coverage while you are on paid leave (so long as 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, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Group Sponsored Insurance and Health FSA coverage, then you may pay your share of the contributions in one of the following ways:

- **Pay-as-you-go:** with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- **Pre-pay:** with pre-tax dollars, by having such amounts withheld from your ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, you must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);

- **Catch-up:** under another arrangement agreed upon between you and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from your Compensation on a pre-tax or after-tax basis) upon your return.

If your Employer requires all Participants to continue Group Sponsored Insurance and Health FSA coverage during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your

share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Employer agree to. If your Group Sponsored Insurance and Health FSA coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

But, despite the preceding sentence, with regard to the Health FSA coverage, if your coverage ceased (e.g., you revoke coverage or choose the Pay-as-you-go option and then fail to pay a required contribution) then you are not entitled to reimbursement for claims incurred during the period when the coverage is not in effect and you may not retroactively elect Health FSA coverage for claims incurred during the period when coverage was not in effect. However, you will be permitted to elect whether to be reinstated in the Health FSA at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA will equal the amount withheld before FMLA leave.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contributions due for you 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 your Employer.

If you go on an unpaid leave that affects eligibility, then the election change rules in Section V Administrative Provisions – Election Changes will apply.

✓ ***How does a leave of absence (such as FMLA) affect my non-health benefits?***
If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as dependent care expenses, etc.) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see above). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Employer and you or as the Employer otherwise deems appropriate. You are not entitled to reimbursements for claims incurred during the period when coverage is not in force.

"Use-it-or-Lose-it" Rule

If the expenses that you incur during your period of coverage in this Plan Year are less than the annual amount that you elected, you will forfeit any amounts that are not eligible for carryover to the following Plan Year.

Therefore, it is important to consider reducing your salary only to pay expenses you are sure you will incur during the Plan Year. Examples of the types of expenses that you know you will incur are regular expenses for items such as braces, insulin or other recurring drug expenses, office visit co-pay charges and weekly or monthly dependent care expenses.

Contributions allocated to one account under a component can only be used to pay claims for that component and no other. For example, amounts credited to your DCE Account cannot be used to pay or reimburse you for an expense under the HRE Account, even if your DCE Account has money in it but your HRE Account has none. Similarly, amounts credited to your HRE Account cannot be used to pay or reimburse you for a dependent care expense under the DCE Account, even if your HRE Account has money in it but your DCE Account has none.

You will forfeit any amounts in your account(s) that are not applied to pay expenses submitted no later than the end of the run-out period following the component's period of coverage end date for which the election was effective. Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the account during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. In addition, any benefit payments that are unclaimed (e.g., uncashed benefit checks) shall be forfeited and applied as described above.

How Benefits are Taxed

Generally, you may not be taxed for the amounts you elect under the Plan. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. **This information is not intended to provide legal or tax advice. You should consult your own personal tax advisor.**

The tax benefits that you receive depend on the validity of the claims that you submit. If you are reimbursed for a claim that is later determined to not be eligible under the Plan, then you will be required to repay the amount. Alternatively, PSA may offset the amount against any other eligible expense submitted for reimbursement or your Employer may withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the Plan constitutes an eligible expense that qualifies for the federal income tax exclusion. Any reimbursement that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your spouse also participates in a DCAP, the maximum amount that you and your spouse together can exclude from taxable income is $5,000.

✓ ***How does enrollment in a DCAP affect my taxes?***
Using a DCAP for reimbursement of dependent care expenses results in a reduction of your taxable salary; therefore, your tax payments are reduced. Depending on your income tax bracket, you may also be entitled to claim the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these (or a combination of the two), but you may not take a tax deduction of those expenses reimbursed under this Plan, or vice versa. For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. And in some cases, the federal tax savings from participating in a DCAP will be only marginally better. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of qualifying individuals, earned

income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you.

Ask your Employer if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that your Employer is not providing legal advice. If you need an answer upon which you can rely, you should consult your own personal tax advisor.

✓ ***If I elect DCAP, do I still report dependent care expenses on my federal income tax return?***

You must file a 2441 Child Care Tax Credit form with your annual tax filing. Your Employer is required to report the amount you elect to withhold from your salary on your IRS W-2 form. You must list the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP Component, although your dependent care expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. For example, if you elect $3,000 in coverage under the DCE Account and are reimbursed $3,000, but you had dependent care expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more qualifying individuals.

Ask your Employer or PSA if you need further information about which expenses are, and are not, likely to be reimbursable.

The Plan Can Be Changed

The Plan is intended to comply with all applicable sections of the Internal Revenue Code and specifically Section 125; therefore, the Plan and any Employer benefit plans offered under the Plan may be amended to comply with the Internal Revenue Code and the Treasury Regulations as they may be amended. In addition, the Plan and any Employer benefit plans offered under the Plan may be amended at any time for reasons other than compliance with new law. Although the Employer expects to maintain the Plan, it has the right to amend or terminate all or any part of the Plan at any time for any reason.

How to File a Reimbursement Request

✓ ***What is required to submit a claim for benefits?***

If you have a claim under an insurance plan or policy, you should follow the claims procedure applicable to that plan or policy, as described in the SPD or similar explanatory booklet available from the insurer.

For claims associated solely with this Plan, you should file your claim for reimbursement as soon as possible after you have incurred the expense. It is not necessary for you to have actually paid the amount due for an expense; only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source. A signed Request for Reimbursement Form is required for all requests that you submit via mail or fax. Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense and the amount of your expense. Further details about what must be

provided are contained in the Request for Reimbursement Form. In some instances, a statement from the provider that a Health FSA expense is medically necessary may be required.

If the Employer implements an electronic payment card plan (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

✓ ***How do I submit a claim for benefits?***
Claims may be submitted the following ways:

- Electronically via our secure web portal: https://psa.consumer.pacificsource.com/
- Faxed with a reimbursement form to (866) 446-6090
- Mailed with a reimbursement form to PO Box 2797, Portland, OR 97208

✓ ***Is there a filing deadline?***
Claims will be paid up to 90 days after the Plan's period of coverage end date. Those submitted after the allowable year-end run-out period may not be paid.

✓ ***What happens if I receive an overpayment?***
If you receive reimbursement and it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to the Plan. If you do not refund the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences for you.

Handling Denied Claims

✓ ***What happens if my claim for benefits is denied?***
If PSA denies a claim, in whole or in part, you will be notified in writing within 30 days of the date PSA receives your claim. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which you can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow you 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on your claim until you provide the specified information.

If PSA denies your claim, you will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information you would need to validate your claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including your right to submit written comments, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals

✓ ***Can I appeal a denied claim of benefits?***

You may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA, in writing, within 180 days of your claim denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied, and should include any additional items or information that you feel supports your claim. The appeal process will provide you with the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

To the extent a dispute arises under the terms of one of the insurance plans or policies, such as a group medical or dental insurance plan offered by your Employer, your ability to appeal decisions under the insurance plan will be outlined in the SPD or similar explanatory booklet available from the insurer.

PSA will review your appeal in a reasonable time, but within 60 days after receiving your request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze your appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of your claim, you will receive a notice of that determination, which will include the following elements:

- The specific reason or reasons for the decision on review;
- The specific Plan provision or provisions that motivated the decision;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If internal rules, guidelines, protocols, or other similar criteria (collectively referred to as "internal guidelines") are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

ERISA Rights

The Premium Payment and the DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Group Sponsored Insurance are governed by ERISA. Note: This SPD does not describe the Group Sponsored Insurance. Consult the Group Sponsored Insurance Plan Documents and the separate SPDs for the Group Sponsored Insurance.

✓ ***Do I have ERISA Rights?***

As a Participant in this Plan**,** you may be entitled to certain rights and protections under ERISA. ERISA does not apply to Employee benefit plans sponsored by governmental entities or churches. **If your Employer is a church or governmental organization (such as a city or school district), ERISA will not apply and you will not have the rights described in this section.**

✓ ***If I have ERISA Rights, what does that mean to me?***

ERISA provides that Plan Participants are entitled to:

- Examine, without charge, at the Employer's office and at other specified locations, such as work-sites and union halls, all Plan Documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Employer is required by law to furnish each Participant with a copy of this SPD.

Fiduciary Obligations

In addition to creating rights for Plan Participants, ERISA imposes duties upon the Employer who is responsible for the operation of an Employee benefit plan. The Employer is called the "fiduciary" of the Plan, and has a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan, or from exercising your rights under ERISA.

Right to Review

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, you must submit this request to PSA, in writing, 180 days of the date of notice of your claim denial. Requests should be submitted to PacificSource Administrators, Attn: Request for Review, PO Box 2797, Portland, OR 97208.

Enforcing your rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Employer 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 Employer. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, 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

Contact your Employer if you have any questions about your Plan, this statement or about your rights under ERISA. If you need assistance in obtaining documents from the Employer, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), requires that the Plan protect the confidentiality of your private health information. The Plan and your Employer, as sponsor of the Plan, will not use or further disclose information that is protected under HIPAA (Protected Health Information or PHI) except as necessary for treatment, payment, healthcare operations and Plan administration, or as permitted or required by law.

As required under HIPAA, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without a written authorization from you, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employment benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your PHI, including the right to review and copy the information, receive an accounting of any disclosures of the information and, under certain circumstances, amend the information. You also have a right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

VI. Notices Required by Law

Qualified Medical Child Support Order
The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)
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 to 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law
"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others imposes strict confidentiality requirements and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)
HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

What is a Qualified Reservist Distribution?

A Qualified Reservist Distribution permits you to take a distribution of the amount you have contributed to the Plan (less reimbursements you have received or distributions previously taken) as of the date you request the distribution. If you are ordered or called to active military duty for 180 days or more you may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. You must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year, if applicable) during which the order or call to active duty occurred. A Qualified Reservist Distribution is included in your gross income and wages, and is subject to employment taxes. You may submit expenses incurred after the date a Qualified Reservist Distribution has occurred. The amount that may be reimbursed is the amount by which you have elected to reduce your Compensation, less the sum of the Qualified Reservist Distribution and the amount of the reimbursements you received as of the date of the Qualified Reservist Distribution.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Employer.