

## **FLEXIBLE BENEFITS PLAN**

### **WHAT IS THE FLEXIBLE BENEFITS PLAN?**

The Flexible Benefits Plan allows you to design a benefits package to suit the individual needs of you and your family and provides you with the following benefit choices:

You may elect to pay your portion of the premium for medical and dental coverage under the Employee Benefit Plan on a pre-tax or after-tax basis.

You may elect to pay the premium for the voluntary vision coverage which Employer makes available to employees on a pre-tax or after-tax basis.

If you certify that you have other medical and prescription drug coverage (for example, through your spouse's employer), you may waive Employer-provided medical and dental coverage and receive additional compensation from Employer.

You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying medical expenses.

You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying dependent care expenses.

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections through the Flexible Benefits Plan are explained in the following sections of this Appendix.

References are made throughout this Appendix to the "plan year." The plan year is the 12-month accounting period for the Flexible Benefits Plan, which is July 1 through June 30. Medical/prescription drug, dental and vision benefits are elected on a plan year basis. However, the plan year for electing the reimbursement of medical expenses or dependent care expenses is January 1 through December 31. Any references to "calendar year" also mean the 12-month consecutive period beginning January 1 and ending on December 31.

### **BENEFIT CHOICES**

For each plan year, you may choose from the following benefits:

#### **Health Insurance Benefits (Medical and Dental Coverage)**

You have two choices with regard to medical/prescription drug and dental insurance coverage for you and your dependents for whom coverage may be purchased on a before-tax basis:

You may elect to receive the coverage and pay your share of the cost with before-tax or after-tax pay reductions. (The default is pre-tax deductions.) The cost of your coverage may depend on various factors, such as whether

coverage is elected for you only or you and one or more of your dependents.

You may elect to waive the coverage. If coverage is waived, you must certify that you have alternate medical and prescription drug coverage. The certification must be on a form provided by Employer for this purpose. If health insurance coverage is waived, Employer will pay additional compensation to you in your paychecks during the plan year for which health insurance coverage was waived. Employer will inform you of the timetable for paying the additional compensation (e.g. in equal installments over each pay period or quarterly, in a lump sum at year end, etc.). The additional compensation is subject to tax withholdings.

### **Voluntary Vision Benefits**

Voluntary vision coverage is available to you and your eligible dependents through Employer. If you want this insurance coverage, you may pay the cost with pre-tax or after-tax pay reductions.

### **Flexible Spending Accounts**

You may use pre-tax pay reductions to obtain reimbursement of qualifying medical expenses and/or dependent care expenses (see the “**YOUR FLEXIBLE SPENDING ACCOUNTS**” section).

### **COBRA Premiums**

If you terminate employment and receive severance pay from Employer, you may elect COBRA and pay your COBRA premiums for health coverage from the severance pay on a pre-tax basis.

## **TAX EFFECT OF PRE-TAX PAY REDUCTIONS**

If you elect medical/prescription drug and dental coverage, voluntary vision coverage, and/or you elect to participate in the flexible spending accounts, your pay will be reduced as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the “**CHOOSING YOUR BENEFITS**” section below). Your premiums for medical/prescription drug and dental coverage and/or voluntary vision coverage will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you will still be required to pay your premium amounts when they are due.

“Pre-tax” pay reductions are not taxable for purposes of either income taxes or FICA. Because you do not pay taxes on your pay reductions, it reduces the net cost for your share of the premiums.

The reduction of your pay for purposes of FICA may cause a small reduction in your future Social Security benefits. You should consult with your tax adviser for more information regarding this issue.

## **CHOOSING YOUR BENEFITS**

This section describes the procedure for choosing benefits under the Flexible Benefits Plan. You may generally not change your election during the plan year, except as described below.

### **Initial Benefit Selection**

Generally, you must make an election before the date that you become a participant in the Flexible Benefits Plan. Employer will inform you of the election procedures. The election process may require completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the “**CHANGING YOUR ELECTION DURING A PLAN YEAR**” section).

There is an exception to these rules if you are a new employee who becomes eligible to participate in the Plan on your date of hire. In this situation, if you make your election within the next 30 days after you start working, the election will be retroactively effective to your first day of employment.

If you do not make an election before the date that you become a participant in the Flexible Benefits Plan, you will receive your regular pay through Employer’s payroll system for the remainder of the plan year and:

You will not be eligible for medical/prescription drug coverage, dental coverage or the voluntary vision coverage for the remainder of the plan year.

You will not be eligible to receive any additional compensation for waiving medical/prescription drug and dental coverage.

Your right to reimbursement from the flexible spending accounts will be waived for the remainder of the plan year.

### **Annual Benefit Selection**

There will be an open enrollment period before the start of each plan year. If you elect to pay your share of the premium for medical/prescription drug and dental coverage and/or or for the voluntary vision coverage on an after-tax basis and/or you elect to participate in the flexible spending accounts, you must make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment

period for that particular benefit or if you have one of the events that permits change during a plan year (see the “**CHANGING YOUR ELECTION DURING A PLAN YEAR**” section).

As previously indicated, there are separate plan years for your election under the Employee Benefit Plan (July 1 through June 30) and your election for the flexible spending accounts (January 1 through December 31).

If you do not make a new election during the open enrollment period, the following default elections will apply:

Your prior elections regarding medical/prescription drug and dental coverage and the voluntary vision coverage will be continued, but on a before-tax basis. You will be considered to have agreed to pay the appropriate premium (if any) for the subsequent plan year for this coverage. If the insurance option(s) in which you are currently enrolled is not being offered during the subsequent plan year, you will be enrolled in the most similar option.

No pay reductions will be credited to your flexible spending accounts for the next plan year.

## **CHANGING YOUR ELECTION DURING A PLAN YEAR**

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election. The next sections describe these situations.

### **Change In Status**

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;

An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;

An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual’s eligibility for benefits;

An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, student status, or any similar circumstance; or

A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Flexible Benefits Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

If you want to decrease or cancel Employer-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.

With respect to your medical spending account, you may elect to decrease your annual contribution amount, but not below the amount that has already been reimbursed to you for the plan year.

With respect to your dependent care spending account, an election change may be made if your dependent attains age 13 or becomes or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

### **FMLA Leaves and Other Approved Leaves of Absence**

If you go on an FMLA leave, you may continue or revoke your elections regarding medical/prescription drug, dental and vision coverage and/or your flexible spending accounts even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

You may continue or revoke your election of these benefits when you begin your FMLA leave.

If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact Employer to discuss the procedures for making the contributions.

If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately--no pre-existing condition provision will apply.

You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

If you take an unpaid FMLA leave and you receive additional compensation from Employer for waiving medical/prescription drug and dental coverage, you will not receive this additional compensation for the time period when you are on the unpaid leave.

If you terminate coverage in your flexible spending accounts during the FMLA leave, your accounts cannot be used to reimburse expenses incurred during the FMLA leave. Also, your total benefits during the plan year may be reduced on a pro rata basis for the time period in which your coverage was not in effect.

If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate.

### **Special Enrollment Rights Under HIPAA**

You may have special rights under HIPAA to enroll in the medical/prescription drug and dental coverage in three situations:

You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the Employee Benefit Plan. (“CHIP” is a state children’s health insurance program.) You must make your new election within 60 days after the event occurs.

### **Court Order**

You may change your election regarding medical/prescription drug and dental coverage or the voluntary vision coverage because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

Elect coverage for the child if the court order requires you to add the child to the Employer-provided health coverage in which you are enrolled; or

Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

### **Medicare or Medicaid Coverage**

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under the Employee Benefit Plan. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under the Employee Benefit Plan.

### **Cost and Coverage Changes**

If the cost of the medical/prescription drug and dental coverage or the voluntary vision coverage changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. However, medical/prescription and dental coverage may be dropped only if you certify that you have other medical/prescription coverage. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

With respect to your dependent care spending account, if the cost of your dependent care provider changes during the plan year you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If the medical/prescription drug coverage, dental coverage or the voluntary vision coverage is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. However, medical/prescription drug and dental coverage may be dropped only if you certify that you have other coverage. Further, if Employer offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under the Employee Benefit Plan.

## **YOUR FLEXIBLE SPENDING ACCOUNTS**

There are certain medical expenses that you or your family may incur that are not covered under the Employee Benefit Plan. Also, if you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these medical and dependent care expenses under your flexible spending accounts. Your flexible spending accounts allow you to pay certain qualifying expenses using “before-tax” income rather than “after-tax” income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The flexible spending accounts operate as follows. Employer will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit you choose for a plan year. For example, if you choose both of the tax-free reimbursement benefits available under the Flexible Benefits Plan, Employer will establish the following accounts in your name:

Medical spending account; and

Dependent care spending account.

Employer will allocate your pay reductions to each account in the amount indicated in your election. When a claim for reimbursement is paid, the amount paid will be subtracted from the applicable flexible spending account. You may not use amounts allocated to one account to receive reimbursement for another type of benefit.

### **Medical Spending Account**

#### **What Amount of Pay Reductions Should I Allocate to My Medical Spending Account?**

It is entirely up to you to determine whether to allocate any pay reductions to your medical spending account and, if so, how much to reduce your pay. Employer will inform you during the open enrollment period of the minimum and maximum amounts you may have credited to your medical spending account for the plan year.

If you know you will have qualifying medical expenses during the plan year which will not be covered by the Employee Benefit Plan or another health plan in which you participate, you should consider putting enough in your medical spending account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying medical expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount to put in your medical spending account, it is wise not to put in too much. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year

(December 31) and the 2½-month grace period (March 15), all unused amounts must be forfeited.

## **What Types of Expenses Are Eligible for Reimbursement From My Medical Spending Account?**

### **Qualifying Individuals**

Qualifying medical expenses may be incurred for:

You;

Your spouse;

Your natural child, your adopted child, a child placed with you for adoption, your step-child or your foster child through the end of the year in which the child turns age 26; or

Other children, relatives and members of your household who are your “qualifying child” or “qualifying relative” under IRS guidelines.

A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18 or 23 (if a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled.

A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual’s financial support and the individual is not the qualifying child of you or any other individual.

### **Qualifying Medical Expenses**

Qualifying medical expenses are generally those types of medical expenses normally deductible on your federal tax return (without regard to the 7.5% of adjusted gross income limitation). They include, for example, expenses you have incurred for:

Copays and deductibles you must pay before your group health plan begins to pay benefits.

Vaccines, medicine and drugs that require a prescription (for example, birth control pills).

Non-prescription drugs purchased to alleviate or treat an illness or injury (for example, an allergy medicine, pain reliever or cold medicine) incurred through December 31, 2010. Effective as of January 1, 2011, over-the-counter drugs and medicines will no longer be eligible for reimbursement under the medical spending account unless specifically prescribed by a physician or the drug is insulin.

Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).

Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition.

Lasik (laser) eye surgery.

Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed as a qualifying medical expense. However, housework may qualify for reimbursement under your dependent care spending account.

Hospital care (including meals and lodging), clinic costs and lab fees.

Medical treatment at a center for the treatment of alcohol or other substance abuse.

Medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining these aids.

Ambulance service and other travel costs to get health care. If you used your own car, you may claim what you spent for gas and oil to go to and from the place you received the care, or you may claim the mileage reimbursement rate allowed by federal law. You may add parking and tolls to the amount you claim under either method.

Expenses for weight-loss programs as a treatment for obesity. This includes the fees to join the program, but not the cost of food.

Massage therapy prescribed by a physician to treat a medical condition.

Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors and on-site health fairs that check items such as blood pressure and cholesterol.

Teeth whitening to correct discoloration caused by disease, birth defect or injury, but not to correct discoloration caused by aging.

Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future, but not if storing it just in case of a future need.

Many of the expenses listed above are covered by the Employee Benefit Plan. Any expense covered by that plan or any other source will not be treated as a qualifying medical expense.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, orthodontia services may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.

### **Special Rule for Health Savings Account Participants**

A health savings account (“HSA”) is a tax-favored IRA type of account established for an eligible individual who is covered only by a qualified high deductible health plan. Employer currently does not offer a qualified high deductible health plan.

If you have a spouse or dependent who participates in an HSA and qualified high deductible health plan (for example, through his or her employer), you should indicate on your election form that you do not want your spouse or dependent to be covered by the medical spending account for the plan year. This is necessary in order for your spouse or dependent to be eligible for HSA contributions because the medical spending account is an ineligible, non-high deductible health plan for HSA purposes.

### **Non-Qualifying Expenses**

You **cannot** obtain reimbursement for the following expenses:

The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain coverage under the Employee Benefit Plan or for the premium you

spouse pays to obtain health coverage under his or her employer's group health plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you may purchase health coverage under other provisions of the Flexible Benefits Plan (see the "**BENEFIT CHOICES**" section above).

Life insurance or income protection policies.

The hospital insurance benefits tax withheld from your pay as part of the Social Security tax.

Illegal operations or drugs.

Non-prescription drugs and medicines used to maintain your good health (for example, dietary supplements and vitamins). Beginning January 1, 2011, all non-prescription drugs and medicines are ineligible unless specifically prescribed by a physician or the drug is insulin.

Items which are considered toiletries (such as toothpaste) or cosmetics (such as face cream).

Travel your doctor told you to take for rest or change.

Items purchased for cosmetic reasons.

Cosmetic surgery, unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease.

Long-term care expenses.

Health club dues.

Expenses reimbursed by an Employer group health plan or any other source.

Expenses incurred before you begin, or after you stop, making contributions to your medical spending account except to the extent you are eligible to submit claims incurred during the 2½-month grace period.

### **How Do I Make a Claim for Reimbursement?**

You should submit your claims for reimbursement of qualifying medical expenses to Employer, using the required claim form. As part of the claim you will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name

of the person for whom the expense was incurred, the name and address of the person or entity to which the expense was paid and a statement that the expense has not been paid or reimbursed by, nor will you seek payment or reimbursement under any other employer-sponsored plan, any federal, state, or other governmental plan or program, or any other source.

Your medical spending account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur \$100 of qualifying medical expenses during the first month of the plan year, you may be reimbursed for those expenses immediately, even if you only have \$50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your medical spending account for the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently than monthly. However, if your total unpaid claims are less than \$10, the claims are held and paid when the total exceeds \$10. The \$10 minimum does not apply, however, at the end of the plan year or subsequent 2½-month grace period and all claims will be paid to the extent of the balance in your medical spending account.

Claims for qualifying medical expenses incurred during a plan year or during the 2½-month grace period ending on the 15<sup>th</sup> day of the third month (March 15) of the next plan year may be reimbursed out of your account balance for the year.

If you submit a claim that was incurred during the grace period and you have an unused account balance with respect to the plan year just ended, you must designate whether you want the reimbursement paid from that account balance or from your account balance for the next plan year. You may not split a claim for a single item between the account balances for the two plan years. To provide you with the most beneficial use of your account, you should request reimbursement from the account balance remaining for the plan year just ended where appropriate.

All claims for reimbursement must be filed no later than 4½ months (May 15) after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the “**Forfeitures**” subsection).

Different rules apply if you terminate participation during the plan year:

If you terminate participation before the end of the plan year, claims for expenses may only be reimbursed if the claims were incurred during the time period in which you were a participant.

For this purpose, if you have unused amounts remaining in your account, you will not be considered to have terminated participation in your

medical spending account until the earlier of the date those amounts are exhausted through reimbursement of eligible claims or the last day of the plan year.

Your medical spending account is not insured. If for any reason the Flexible Benefits Plan or Employer does not ultimately reimburse you for expenses that are eligible for reimbursement, you may be liable for the expenses.

### **HIPAA Privacy**

The medical spending account is subject to the HIPAA privacy rules. You will receive a notice of Employer's privacy practices which will explain, in detail, the HIPAA privacy rules and your privacy rights.

### **Dependent Care Spending Account**

#### **What is the Difference Between My Dependent Care Spending Account and the Dependent Care Tax Credit?**

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "before-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to \$3,000 for one child and up to \$6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

#### **What Amount of Pay Reductions Should I Allocate to My Dependent Care Spending Account?**

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you want to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (December 31) and the 2½-month grace period (March 15), all unused amounts must be forfeited.

## **What Types of Expenses Are Eligible for Reimbursement From My Dependent Care Spending Account?**

Your dependent care expenses may be reimbursed under the Flexible Benefits Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by Employer.

The Internal Revenue Code defines who is considered your dependent for this purpose:

Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

Care for your dependent in your home (such as babysitting), if the dependent is either:

Your qualifying child under age 13; or

Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

Under age 13; or

Totally disabled (as defined above) and regularly spends at least eight hours per day in your home.

This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

Household services for the maintenance of your home (such as for a domestic maid or cook) as long as the services are performed in part for the benefit of your dependent.

### **May Amounts Paid to My Relatives Be Reimbursed?**

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Flexible Benefits Plan if one of the following relatives provides the care:

One of your dependents;

Your spouse; or

Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

### **Are There Limits on How Much May Be Reimbursed?**

Federal law limits the amount of dependent care expenses which may be reimbursed under the Flexible Benefits Plan. Generally, the limit is \$5,000 per calendar year (or \$2,500 if you are married and file a separate tax return).

However, if you earn less than \$10,000 or your spouse earns less than \$5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

\$250, if you have dependent care expenses for one dependent; or

\$500, if you have dependent care expenses for more than one dependent.

### **How Do I Make a Claim for Reimbursement?**

You should submit your claims for reimbursement of dependent care expenses to Employer, using the required claim form. As part of the claim you will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently than monthly. However, if your total unpaid claims are less than \$10, the claims are held and paid when the total exceeds \$10. The \$10 minimum does not apply, however, at the end of the plan year or subsequent 2½-month grace period and all claims will be paid to the extent of the balance in your dependent care spending account.

Claims for dependent care expenses during a plan year or during the 2½-month grace period ending on the 15<sup>th</sup> day of the third month (March 15) of the next plan year may be reimbursed out of your account balance for the year. If you terminate participation before the end of the plan year, the amount remaining in your account may continue to be applied toward the reimbursement of qualifying dependent care expenses incurred through the end of the plan year in which your participation terminated. If you continue to actively participate for the entire year and you submit a claim that was incurred during the grace period and you have an unused account balance for the plan year just ended, the reimbursement will be credited against that account balance first until it is exhausted before being credited against your account balance for the next plan year. This allocation will occur after the grace period ends, to provide you with the most beneficial use of your account.

All claims for reimbursement must be filed no later than 4½ months (May 15) after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the “**Forfeitures**” subsection).

## **Other Rules Regarding Your Flexible Spending Accounts**

### **Termination of Participation**

If you terminate employment or otherwise become an ineligible participant under the Flexible Benefits Plan, you will be ineligible to have any additional pay reductions credited to your medical spending account or dependent care spending account. If you have amounts remaining in your medical spending account or dependent care spending account, you may continue to turn in claims for reimbursement of expenses incurred before you terminate employment.

In addition, if the amount contributed to your medical spending account or dependent care spending account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to be reimbursed for claims incurred after you terminate employment.

If you participate in the medical spending account and you go on a military leave of absence, Employer will comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements will only apply to the extent they provide you with more favorable coverage than under COBRA (i.e., coverage for a longer period of time or less costly coverage).

### **Forfeitures**

Your pay reductions for each plan year may generally only be used to reimburse qualifying expenses incurred during that plan year. The only exception is that amounts in your medical and dependent care spending accounts at the end of a plan year may be used to reimburse qualifying medical and dependent care expenses incurred during the first 2½ months of the next plan year. An expense is “incurred” when the service is rendered or the supply is provided. However, see the special rule regarding orthodontia services in the last paragraph of the subsection entitled “**Qualifying Medical Expenses.**”

Federal law requires the forfeiture of amounts remaining in your flexible spending accounts after expenses incurred during the plan year or the subsequent 2½-month grace period are reimbursed. A forfeiture will occur if you fail to use the entire amount in your medical spending account and dependent care spending account. You are not allowed to transfer unused amounts from one spending account to another spending account. You should be careful not to overestimate your expected expenses when you make your election. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.