FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN
EMPLOYER INFORMATION

1) Name and Address of Employer / Plan Administrator: **SARAH LAWRENCE COLLEGE**
LOIS BOOTH
1 MEAD WAY - HUMAN RESOURCES
BRONXVILLE, NY 10708

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number: **(914) 395-2364**
3) Employer's Federal Tax Identification Number: **23-7223216**
4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned): _____
5) 125 Start Date: **11/01/03**
6) Effective Date of this Plan: **01/01/04**
7) Last Day of the Plan Year: **12/31/04**
Subsequent Plan Years: **01/01-12/31**
8) Name and Address of Plan Service Provider: **CLAIMS PROCESSOR: FLEX ONE**
1932 WYNNTON ROAD
COLUMBUS, GA 31999
9) Name and Address of registered agent for service of legal process: **JULIE AUSTER**

10) Affiliated Employers that will participate in the Plan (affiliates in excess of 30 are listed in Appendix 1 and are mailed

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11) Employer's Type of Business: **CORPORATION**

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan except the following:

An eligible Employee may become a Participant in the Plan:

( ) Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).
( ) On the **day** following commencement of employment.
(X) On the first day of the month following **1** days of employment.
( ) Other: **OTHER**
provided the Employee completes a Salary Redirection Agreement ("SRA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

( ) On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.
( ) On the day following commencement of employment.
( ) On the first day of the month following days of employment.
( ) Other: **OTHER**, provided the Employee completes an SRA selecting such benefits.

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the SRA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

(X) Medical Coverage
(X) Vision Care Coverage
( ) Disability Income - Short Term (A&S)
(X) Cancer Insurance
(X) Group Dental Coverage
( ) Group Term Life Insurance
( ) Disability Income - Long Term (LTD)
( ) Intensive Care Insurance
( ) Accident Insurance
( ) Hospital Indemnity Insurance (HIP)
( ) Specified Health Event
( ) Personal Sickness Indemnity (PSI)
(X) Medical Care Expense Reimbursement described in Appendix II to this SPD, not to exceed $ **3,500** per Plan Year pursuant to the **SARAH LAWRENCE COLLEGE** Medical Care Expense Reimbursement Plan.
(X) Dependent Care Expense Reimbursement described in Appendix II to this SPD, not to exceed $5,000 per Plan Year or $2,500 for married filing separate returns pursuant to the **SARAH LAWRENCE COLLEGE** Dependent Care Expense Reimbursement Plan.
( ) Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one):

❑ The Employer, which will comply with the requirements of Article VII of the Plan.
❑ The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

❑ The Employer, except as otherwise noted in the Plan.
❑ The Participants, except as otherwise noted in the Plan.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

Questions & Answers about the Flexible Benefits Plan

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

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will **automatically** cease, and you will not be able to make any more Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by signing an individual Salary Redirection Agreement ("SRA") on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided an SRA when you first become eligible to participate in this Plan. You must complete the form and turn it in to the Personnel Office during the applicable enrollment period described in Q-6 below.

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

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file an SRA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting an SRA prior to the beginning of each Plan Year -- no deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Monthly Savings: $31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the SRA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

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

- a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
- a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

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

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to <u>increase</u> your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

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- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

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

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

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

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

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

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

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

5. **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical Care Reimbursement Plan, to the extent offered under the Plan.)

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

6. **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Medical Care Reimbursement Plan, to the extent offered under the Plan.)

Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

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

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review. The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation 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) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

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(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.

APPENDIX I TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Medical Care and Dependent Care Reimbursement Plan Summary Plan Description

To the extent elected by the Employer (indicated in the Plan Information Summary attached to this SPD), you will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Reimbursement Plan ("URM") and/or some or all of your work-related Dependent care expenses under the Dependent Care Reimbursement Plan ("DDC") (collectively, the "Reimbursement Plans"). Under the URM and DDC, you purchase a specific level of reimbursement benefits and you provide a source of pre-tax funds to reimburse yourself for your Eligible Expenses. For both, you pay for coverage through the Salary Redirection Agreement ("SRA") with the Employer, in lieu of receiving a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save Social Security and income taxes on the amount of your salary conversion.

By enrolling in either the URM or DDC option and submitting reimbursement claims you **specifically** authorize the Plan, AFLAC® and AFLAC Administrative Services/FLEX ONE®, and their respective agents, employees, sub-contractors, and assigns to use your personal health information in their possession to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation, and to further disclose such information as is reasonably required for those purposes. You further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or for detecting or preventing fraud or misrepresentation. You further waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of administering the Plan (including processing or evaluating a claim for benefits under the Plan) or to detect or prevent fraud or misrepresentation. This authorization does not and is not intended to in any way limit any right the Plan, AFLAC and AFLAC Administrative Services/FLEX ONE®, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

General Questions and Answers

Q-1. Who can participate in the URM and/or DDC?

Each employee who satisfies the eligibility requirements described in the Plan Information Summary is eligible to participate in the Reimbursement Plans as of the eligibility date described in the Plan Information Summary.

Q-2. How do I become a Participant?

You become a Participant by electing URM and/or DDC benefits during the Initial or Annual Enrollment Periods. (The Initial and Annual Enrollment Periods are described in Q-6 of the Flexible Benefits Plan SPD.) Your participation in the URM or DDC will be effective on the date that you make an election to participate or the eligibility date described in the Plan Information Summary, whichever is later. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-9 of the Flexible Benefits Plan SPD. Once you become a Participant in the URM, you may also receive reimbursements for Eligible Medical Expenses incurred by your "Eligible Dependents". For purposes of the URM, Eligible Dependents include your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and any other individuals who would qualify as a tax Dependent under Code Section 152 for purposes of your federal income tax return.

If the Plan Administrator receives a qualified medical child support order relating to the URM, the URM will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your Health Care Account (See Q-3 below), it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

Q-3. What are my "URM Account" and my "DDC Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing account will be established under each Plan to keep a record of the reimbursements you are entitled to under each Plan, as well as the contributions you have made for such benefits during the Plan Year. No actual accounts are established; they are merely bookkeeping accounts.

Q-4. When does coverage under the URM and/or DDC end?

You continue to participate in the URM and/or DDC until (i) you elect not to participate in accordance with Q-9 of Flexible Benefits Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period; (iii) you no longer satisfy

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the eligibility requirements described in the Plan Information Summary; (iv) you terminate employment with the employer; or (v) the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You are not eligible to receive reimbursement for otherwise Eligible Medical Expenses incurred during the Plan Year after you cease to be eligible unless you elect COBRA continuation coverage (as described below in Q-19 of this Appendix), provided you are eligible to elect COBRA. However, you will be eligible to receive reimbursement under the DDC for Eligible Employment-Related Expenses (as defined in Q-9 below) incurred during the plan year but after you cease to be eligible up to your account balance as of the date you cease to be eligible.

Coverage under the URM for your Eligible Dependents ends on earliest of the following to occur: (i) your coverage ends; (ii) the individual ceases to be an Eligible Dependent (e.g. divorce or legal separation from the spouse); or (iii) the Plan is terminated or amended to exclude individual or the class of individuals of which the individual is a member (spouse or dependent child) from coverage under the URM. Your Spouse and/or your Dependent children may also be entitled to COBRA continuation coverage if coverage is lost for certain reasons. See Q-19 of this Appendix for more information on COBRA.

Q-5. What happens to my URM Account and/or DDC Account if I take an approved leave of absence?

Generally, the rules described in Q-13 of your Flexible Benefits Plan SPD apply. However, if your URM coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the URM at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a URM reimbursement level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your URM coverage was not in effect are not eligible for reimbursement under this URM.

Q-6. What is the maximum URM and/or DDC benefit I may elect?

For URM, you may choose any amount of annual reimbursement you desire subject to the maximum reimbursement amount set forth in the Employer Information Section of the Plan Information Summary.

For DDC, this is set forth in the Employer Information Section, however, this amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently $5,000 per Plan Year if you -

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

If you are married and reside together but file a separate federal income tax return, the maximum DDC benefit you may elect is $2,500.

You will be required to pay the annual contribution equal to the coverage level you have chosen.

Q-7. How is my Medical Care and/or Dependent Care Expense Reimbursement benefit paid for and what amounts will be available at any particular time during the Plan Year?

For URM and DDC, when you complete the SRA, you specify the amount of Medical Care and or Dependent Care Expense Reimbursement(s) you wish to pay for with your Pre-tax Contributions. Thereafter, you must make a contribution for such coverage by having an equal portion of the annual reimbursement amount deducted from each paycheck. Your employer will distribute benefit payments from its general assets.

For URM Benefits, the full amount of the coverage you have elected, reduced by the amount of prior reimbursements received during the Plan Year, will be available to reimburse you for your out-of-pocket medical expenses incurred at any time during the Plan Year and while you are a Participant. For DDC Benefits, the amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Account less any reimbursements already paid.

Q-8. How do I receive reimbursement under the Plan?

If you elect to participate in URM or DDC, you will have to take certain steps to be reimbursed for your Eligible Medical and/or Eligible Employment-Related Expenses (as defined in Q-9 below). When you incur an expense that is eligible for payment, you submit a request to the Plan's Administrator on a Request for Reimbursement form that will be supplied to you.

For URM and DDC, you must include written statement(s)/bill(s) from an independent third party(ies) stating that the eligible expenses have been incurred, and the amount of such expense(s) along with the Request for Reimbursement form. In addition, you must include for URM claims an Explanation of Benefits (EOB) form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay.

For DDC, if your reimbursement request is for an amount that is more than your current Account balance, the excess part of the reimbursement will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total Dependent Care expenses above your available, annual credits to your Account.

With respect to either DDC or URM benefits, you may not be reimbursed for any expenses that arise before your SRA becomes effective, or for any expense incurred after the close of the Plan Year.

To have your Request for Reimbursements processed as soon as possible, please read the reimbursement instructions on the back of the Request for Reimbursement form you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Medical and/or Eligible Employment-Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. In addition, you will have 90 days after the end of the Plan Year in which to submit a Request for Reimbursement form for Eligible Expenses incurred during the previous Plan Year. You will be notified in writing if any Request for Reimbursement is denied.

Q-9. What is an "Eligible Expense?"

For URM, an "Eligible Expense" generally means any item for "medical care" as defined by Code Section 213(d) for which you have not received reimbursement and will not seek reimbursement from insurance, or some other source and for which you will not or have not taken a deduction under Code Section 213. "Medical Care" means amounts for diagnosis, treatment or prevention of a specific medical condition or to affect a function or structure of the body. Expenses solely for general well-being are not "medical care" expenses. Premiums for accident or health insurance and expenses for qualified long term care services are not Eligible Medical Expenses for purposes of this Plan.

For DDC, you may be reimbursed for work-related expenses ("Eligible Employment-Related Expenses") incurred on behalf of any Qualifying Individual described below. Generally, these expenses must meet all of the following conditions for them to be Eligible Employment-Related Expenses:

- The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.
- Services are incurred for a Qualifying Individual. A Qualifying Individual is
  1. a Dependent under age 13 for whom you are entitled to a personal tax exemption as a Dependent, or
  2. a Spouse or other tax Dependent who is physically or mentally incapable of caring for himself or herself.
- The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.
- If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
- If the expenses are incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.
- This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:
  1. $5,000
  2. $2,500, if you are married but you and your Spouse file separate tax returns.
  3. Your taxable compensation (after your Pre-tax Contributions have been deducted under the Plan).
  4. If you are married, your Spouse's actual or deemed Earned Income.

  For purposes of (4.) above, your Spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself or (ii) a full-time Student.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-10. When must the expenses be incurred?

Eligible Medical and Employment-Related Expenses must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your SRA becomes effective, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage and certain Eligible Employment-Related Expenses, after a separation

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from service. You may be reimbursed for Eligible Employment-Related Expenses that are incurred after a separation from service up to your account balance on the date of separation from service. In addition, IRS regulations require that service or treatment be actually rendered prior to the time that the expense is reimbursed. Therefore, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (e.g., orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied.

Q-11. What if the Eligible Medical or Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Care and/or Dependent Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. This is called the "Use-It-or-Lose-It" Rule. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the ninetieth (90th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-12. Will I be taxed on the DDC benefits I receive?

You will not normally be taxed on your DDC benefits, up to the limits set out in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-13. What is the household and Dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment-Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment-Related Expenses (to a maximum credit amount of $1050 for one Qualifying Individual or $2100 for two or more Qualifying Individuals) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment-Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1152, because the entire $3,600 expense would have been taken into account, not just the first $3,000.

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

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified Dependent care expenses may be eligible for the Dependent care credit.

Q-15. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in a lower income tax bracket, you may come out ahead by including the DDC benefits in income, and claiming the credits for Dependent care. On the other hand, it will generally be better to treat DDC benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-16. What happens to unclaimed Reimbursements?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical and/or Employment-Related Expense was incurred shall be forfeited.

Q-17. What happens if a Claim for Benefits under the URM or DDC is denied?

You will be notified if your claim under the Plan is denied. The notice will be furnished to you as soon as reasonably possible but no later than 30 days after the Plan Administrator (or its designated claims administrator identified in the reimbursement form) receives your claim. However, if for reasons beyond the control of the claims reviewer, more time for processing your claim is needed, the applicable claims reviewer may take an extension of not more than 15 days following the end of the 30-day period. You will be notified of this extension before the initial 30 days has expired, and the notice will explain why an extension is necessary and the date a decision is expected to be rendered. If the reason for the extension is because you failed to submit complete information necessary to decide the claim, you will have 45 days from the notice of the extension in which to provide the information. The time period for making a decision will be suspended until the earlier of the date that you submit the necessary information or the end of the 45-day period.

The notice of the denial will include the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary;
- instructions on how to appeal the denied claim (including the applicable time periods) and the identity of the individual(s) who will review the denied claim; and
- Any other information required by applicable law.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. The notice will contain the same type of information described above and it will indicate whether there are one or two levels of appeals. If there are two levels of appeals, the decisions on review will be made no later than 30 days after the request for each review is received. The reviews upon appeal (whether one level or two) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in a previous review. In no event will a determination upon review be made by the same individual(s) who made previous determinations or someone who is a subordinate of any individual who made such previous determinations. The Plan Administrator is the claims fiduciary responsible for making final claim decisions under the Plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-18. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the URM only, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

<u>When Coverage May Be Continued</u>

If you are a Participant in the URM, then you have a right to choose continuation coverage under the URM if you lose your coverage because of a reduction in your hours of employment; or a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage due to the death of your Spouse; a voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment; or the divorce or legal separation from your Spouse.

In the case of a Dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost because of: the death of the employee; a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment; his or her parents' divorce or legal separation; or his or her loss of Dependent status. A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries."

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Type of Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If you do not choose continuation coverage, your coverage under the URM will end with the date you would otherwise lose coverage.

Notice Requirements

You or another Qualified Beneficiary must notify the employer of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. An employee or covered Dependent is responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

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

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the URM and DDC indefinitely, it has the right to modify or terminate the programs at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-20. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the URM and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. Attached as Appendix II to this SPD (included in the HIPAA packet) is a summary of your rights and obligation under HIPAA. You may receive a separate notice that outlines the Employer's health privacy policies in more detail.

Q-21. Is there any other important information that I should know about the Reimbursement Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name has also been provided in the Plan Information Summary.

ERISA Rights

The URM may be an ERISA welfare benefit plan (unless the employer is a governmental employer or the plan is a "church plan" as defined in the applicable regulations). As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-19 of this appendix for more information concerning your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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 lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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Assistance with Your Questions

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

APPENDIX II TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Summary of Privacy Policies and Procedures

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the URM claims reimbursed under the Plan for Plan administration purposes. This summary applies to all of the medical records we maintain with regard to the URM. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with health coverage under the URM, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. In accordance with Section 10.18 of the Plan, the following is a summary of procedures adopted by the Employer to ensure that both the Employer and any third party service providers treat your PHI with the level of protection required by HIPAA. You may receive a separate notice that provides more detailed information regarding the procedures adopted by the Employer.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. **In the event this summary conflicts with the separate Privacy Notice from your employer, the separate Privacy Notice controls.**

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. Except as otherwise provided in the separate Privacy Notice that may be provided to you, these employees consist of the members of the Personnel Benefits Department of the Employer who assist in administration of URM claims. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. The Employer will establish an effective mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of this SPD, the Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of URM administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

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Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Personnel/Benefits Office, except as otherwise set forth in any separate Privacy Notice provided to you by the Employer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Personnel/Benefits Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Restrictions. To the extent set forth in the separate privacy notice, you may have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations, or you may have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Personnel Office except as otherwise provided in the separate privacy notice. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

When Employer no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Personnel Office except as otherwise provided in the separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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