Summary Plan Description 2010

Laramie County Employees Flexible Benefits Plan
Plan Year Ending June 30, 2011
Amended July 1,2010

FLEXIBLE BENEFITS PLAN

Summary Plan Description

INTRODUCTION

We are pleased to announce that Laramie County Employees elects to amend the Flexible Benefits Plan (the "Plan") for you and other eligible employees. Under this program, you will be able to choose among certain Benefits that we make available. The Benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the Benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the Benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Administrator. There is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an Insurance Contract and either the Plan Document or this Summary Plan Description, the Insurance Contract will control.

I - GENERAL INFORMATION
Laramie County Employees Flexible Benefits Plan

This Section contains certain general information, which you may need to know about the Plan.

1. The **Name of the Employer, Plan Sponsor** and **Plan Administrator** is **Laramie County Employees.**

   Laramie County Employees
   310 W 19th Street Suite 320
   Cheyenne, WY 82001

   Telephone #: 307-633-4355 **EIN: 83-6000111**

   The Administrator keeps the records for the Plan and is responsible for the Plan. The Administrator may be contacted and answer any questions regarding the Plan.

2. **Employer's Principal Office:** This Flexible Benefits Plan shall be governed under the laws of the State of Wyoming.

3. **Plan Number (IRS Plan Code): 501**

4. **Plan** and **Plan Year:** The Name of the Plan shall be the Laramie County Employees Flexible Benefit Plan (the "Plan"). The initial Plan Year began July 1, 1992 and ended June 30, 1993. Future Plan Years will be based on a full twelve-month period beginning each July 1 and ending each June 30.

5. **Effective Date:**
   - This amended Flexible Benefit Plan shall be effective as of July 1, 2010.
   - If amended, the Plan was originally effective July 1, 1992.

6. **Open Enrollment for eligible employees will be:**
   - 60 days prior to the beginning of the plan year.

7. **Plan Entry Date** (Eligible Employees become effective to participate)**:**
   - Same as Employer's group health insurance plan.

8. **Eligible Employees Included in the Plan:**
   - Employees **eligible** to participate in employer group health insurance plan.

PLEASE NOTE: IRS REGULATIONS PROHIBIT ELIGIBILITY FOR THE FOLLOWING INDIVIDUALS WHO MAY BE PARTICIPAING IN THE HEALTHCARE FLEXIBLE SPENDING ACCOUNT:

- Individuals who qualify as an Eligible Individual for a Health Savings Account under Code Section 223(c) and are enrolled.

9. **Change of Election based on Eligible Status Changes:**
   A Participant must provide in writing to Human Resources within 30 days of the change in family status. If the Benefit allows for a change in Contribution and Annual Election based on Change of Status, the appropriate forms may be completed for a change in Salary Redirection. Other changes in Elections may only be elected during Open Enrollment or other qualifying events.

10. **<u>Employee</u> Contributions for Participants Entering Mid Year:**
    - Employee annual Election shall be allowed at the full year maximum amount based on payroll and salary availability.

11. **Maximum Allowable Contributions:**
    The contributions for this Plan shall be:
    - Premium Only Plan: Employer and Employee contributions shall not exceed annualized insurance premiums adjusted for any rate increases or decreases during the Plan Year.
    - Maximum Allowable Flexible Spending Account Contribution
      - Healthcare Flexible Spending Account $1000.00
      - Dependent Care Assistance Flexible Spending Account $5,000.00
        1) Subject to Earned Income limitations and
        2) $2500 if filing separate tax returns
        3) IRS limitation of $5000 filing joint return

The Social Security taxable wage base for 2010 is $106,800. The tax rate for employee withholdings, including Social Security and Medicare is 7.65%. The Social Security rate of 6.2% is applied to taxable wages up to the maximum taxable amount for the year, $106,800. The Medicare rate of 1.45% is applied to all wages.

2010	$ 106,800	2011	$ 106,800 (estimate)

12. **Benefits:**
    - Premium Only Plan Benefits
      - Group sponsored health insurance premiums
      - Dental insurance premiums
    - Healthcare Flexible Spending Account available to reimburse medical expenses not covered by insurance.
    - Dependent Care Assistance Flexible Spending Account available for eligible adult and child daycare.

13. **Claims Extension (Grace) Period**
    The Plan shall be subject to the terms and conditions of Section 12.16 Claims Extension Period. This extension or grace period allows for an employee to submit claims incurred after the end of the plan year. If an Employee has a remaining balance in the prior plan year, the employee may incur claims during the claims extension (grace) period and still be reimbursed money from the

prior plan year. This reduces the "use it or lose it", by allowing a short period of time to minimize the potential of forfeiting any contributions.

- Healthcare Flexible Spending Claim Extension (Grace) Period shall be September 15, 2011.
- Dependent Care Assistance Program Claim Extension Period shall be September 15, 2011.

14. Claims Timely Filing Limitation Period For Active Employees:

The Plan shall be subject to the terms and conditions of Section 12.16 Claims Extension Period.

- The Employee has until October 15, 2011 **after the Grace Period** to submit claims for the Healthcare Flexible Spending Account and October 15, 2011 **after the Grace Period** to submit claims for the Dependent Care Assistance Program. All claims must be incurred during the plan year and applicable extension (grace) period.

15. Claims Timely Filing Limitation Period For Retirees who retire under the Employer's Retirement Program:

- Retiree Healthcare Flexible Spending Timely Filing Limitation Period shall be 30 days from date of retirement to submit claims incurred prior to retirement.

16. Claims Timely Filing Limitation Period For non COBRA Terminated Employees for Healthcare Spending Account:

- An Employee terminating employment shall have 15 days after termination to submit claims incurred prior to termination.

17. Claims Timely Filing Limitation Period For Terminated Employees for Dependent Care Assistance Program Spending Account:

- An Employee terminating employment shall have 15 days after termination with the employer to submit claims incurred prior to termination.

18. Healthcare FSA COBRA will be administered by:

- FlexShare Benefits c/o Blue Cross Blue Shield Wyoming.

19. All Employees, other than Retirees, leaving employment for any reason:

- Shall be governed by Special COBRA Limited Obligation.

20. Special COBRA Limited Obligation Qualifications:

Certain Employers qualify for COBRA special rules and regulations. Your Employer qualifies:

- If certain conditions are met, this Health FSA qualifies for Special COBRA rules (1) Maximum Annual Benefit Test; (2) Major Medical Coverage available to all participants; (3) Annual COBRA premium equal or greater than Annual Election.
- If rules apply, and the employee's account is under spent at time of qualifying event, COBRA may be offered only through year end with no annual open enrollment rights.
- If rules apply, and the employee's account is over spent at the time of qualifying event, there is no requirement to offer COBRA.

21. A "Qualified Reservist Distribution" is any distribution of all or part of a Participant's existing Healthcare Flexible Spending Account balance made:

- When the Participant is (by reason of being a member of a reserve component (as defined in Section 100 of Title 37, United States Code)) ordered or called to active duty for a period in excess of 179 days or for an indefinite period, and
- Such distribution is made during the period beginning on the date of such order or call and ending on the last date that the reimbursement can be made per the Plan for the Plan Year which includes the date of such order or call.
- Must be requested by a Participant in writing within the guidelines of the applicable grace period (if any) and timely filing limitations.
- Account balance shall be the amount contributed to the Healthcare Flexible Spending Account as of the date of the Qualified Reservist Distribution request minus Healthcare Flexible Spending Account reimbursements requests received as of the date of the Qualified Reservists Distribution request.

22. Experience Gain Options

If experience gains of the Plan are in excess of the experience losses of the Plan the Employer has elected to:

- Return surplus gain for the prior year to the Administrator (Employer) to defray experience losses and administrative expenses for the Plan.

23. Healthcare Flexible Spending Account in addition to a Health Savings Account Expense Allocation and Order of Benefit Payments:

If the Employer sponsors a Healthcare Flexible Spending Account in addition to a Health Savings Account for Eligible Employees: ***CAUTION: only certain type of Medical Spending Accounts may be established in conjunction with a Health Savings Account.***

- Not Applicable.

24. Service of Legal Process. The Administrator is the Plan's agent for service of legal process.

25. Type of Administration. This Plan is Employer Administered.

II - ELIGIBILITY

1. When can I become a Participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules that you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the Entry Date that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan. Please refer to Section I, General Information of this document for a description of the Entry Date for our plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the eligibility requirements under this Plan. Please refer to Section I, General Information of this document for a description of our eligibility requirements.

3. When is my entry date?

Once you have met the eligibility requirements, your entry date will be the first day you are eligible to participate in the specific benefit option. This may be the date you are enrolled your group sponsored health insurance plan or another date depending on the benefit option, and when you meet the eligibility requirements. Refer to Section I, General Information, for individual benefit entry dates.

4. Are there any Employees who are not eligible to participate?

Yes, there are certain employees who are not eligible to join the Plan. Please refer to Section I, General Information of this document for a description of ineligible employees.

5. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the Benefits that are being offered under the Plan. You must also authorize us to set aside some of your earnings to pay for a portion of the Benefits you have elected.

However, if you are already covered under any of the insured Benefits, you will automatically participate in this Plan to the extent of your Premiums, unless during the Election Period, you elect not to participate in the Plan.

III - OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts, which must be set up for you in order to pay for the Benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal or Social Security taxes and in most cases State income taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you would normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

IV - CONTRIBUTIONS

1. Will my employer make contributions to the Plan on my behalf?

Your Employer may choose to make contributions to the Plan to assist you in offsetting the cost of Benefits offered under the Plan. These Employer Contributions are referred to as "Flexible Benefits Plan Dollars." Please refer to Section I, General Information, to determine what, if any, amount your Employer has indicated it will contribute towards the cost of your Benefits under this Plan.

2. How much of my pay may the employer redirect?

To the extent your Employer either does not provide Flexible Benefits Plan Dollars to this Plan or the cost of Benefits offered under the Plan are greater than the Flexible Benefits Plan Dollar amount provided by your Employer, you may make an election, known as a Salary Redirection, to make additional pre-tax contributions to the Plan from your own Salary amount. Each year, for the insured Benefits provided under this Plan we will automatically contribute on your behalf enough of your Compensation to pay for the insurance coverage provided. In addition, you may elect to pay for the Benefits that you elect under the Plan. These amounts will be deducted from your Compensation each pay period on a pro rata basis over the course of the year.

3. How is my compensation measured under the Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

4. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the Benefits you want and how much of the contributions should go toward each Benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered Benefit or expense during the Plan Year. Later, they will be used to pay for expenses as they arise during the Plan Year.

5. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the Election Period. You must decide two things; first, which Benefits you want, and second, how much should go toward each benefit.

If you are already covered by any of the insured Benefits offered by this Plan, you will automatically become a Participant to the extent of the Premiums for such insurance unless, during the Election Period, you elect not to participate in the Plan.

6. When is the "Election Period" for our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your Entry Date. (You should review Section I, General Information and Section II, "Eligibility" to better understand the terms "eligibility requirements" and "Entry Date.") Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See Section I, General Information for the definition of "Plan Year.")

7. May I change elections during the Plan Year?

Generally no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change if you have a "change in status," you make an election change that is consistent with the change in status, and provided your request for change is made within 30 days from the date of change in status. Any new election will be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. Currently, Federal law considers the following events to be changes in status:

a) Changes in legal marital status by you because of marriage, divorce, death of a spouse, legal separation, or annulment;
b) Changes in the number of your dependents because of a dependent's birth, adoption, placement for adoption, or death;
c) Changes in your employment status because of employment termination or commencement by you, your spouse, or a dependent; strike or lockout; the beginning or end of an unpaid leave of absence; or any other change in employment status that affects eligibility for benefits;
d) Changes in one of your dependents who satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or a similar circumstance;
e) Changes in health plan access due to a change in residence or worksite by you, your spouse, or a dependent that affect eligibility for benefits;
f) Changes due to judgment, decree, or order resulting from divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order. You

may also change an election to cancel coverage for the child if the order requires a former spouse to provide coverage for such child and such coverage is actually provided.

g) Changes due to entitlement to Medicare or Medicaid;
h) Changes due to entitlement to health insurance continuation coverage, as prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended; application of the Family and Medical Leave Act of 1993 ("FMLA"); or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, the Salary Redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If there is an increase or decrease in premium expense that is significant, we will let you either make corresponding changes to the Salary Redirection election or allow you to revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may change or revoke your election. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly added option, elect another option if an option has been eliminated, or revoke your election. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Healthcare Flexible Spending Account, and you may not change your election to the Healthcare Flexible Spending Account if you make a change due to cost or coverage for insurance.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be your qualified dependent will qualify as a change in status. However, you may not change your election under the Dependent Care Assistance Program if it is due to a cost change, and a dependent care provider who is your relative imposes that change. You may, however, change your election under the Dependent Care Assistance Program if there is a cost change imposed by a non-related dependent care provider.

There may be other events considered to be a change in status as determined by the IRS regulations. There are detailed rules on when a change in election is deemed to be consistent with a change in status. If you have any type of change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections.

The Administrator makes the determination of whether a valid change of status has occurred. In making this determination, the Administrator has the authority to require additional evidence to support your stated reasons for changing any prior benefit election.

8. May I make new elections in future Plan years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not

make new elections during the election period before a new Plan Year begins, you will be considered to have elected to have a portion of your pay redirected for the upcoming Plan Year for the premium portion of this Plan only. You would not be considered a Participant for the Healthcare Flexible Spending Account or the Dependent Care Assistance Account portions of the Plan without completion of new elections prior to the beginning of the subsequent Plan Year.

9. How does the Family and Medical Leave Act (FMLA) affect this Plan?

FMLA only applies to Employers who employee over 50 employees within 75 miles of the worksite, and at least 50 of your employees work 20 or more work-weeks in the current or preceding calendar year. If your company is a public agency, you are subject to provide FMLA regardless of the number of employees employed. All schools, private or public, are considered public agencies.

Generally, if you go on a qualifying 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 benefits under this Plan on the same terms and conditions as though you were still an active Employee. If you take a paid leave under the FMLA, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the Premiums being paid by the method normally used during any paid leave. If you take an unpaid leave under the FMLA, you may revoke or change your existing elections for health insurance and the Healthcare Flexible Spending Account, and participate in annual enrollment.

Or, your employer may choose to continue coverage on your behalf during your FMLA leave. In such situations, you would be entitled to receive reimbursement of any qualifying expenses that you incurred during your FMLA leave period. However, if you continue your coverage during your unpaid leave, you may continue to make payment for coverage under one of the following methods:

a) **Prepayment.** Under the prepayment option, you can increase your Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.
b) **Pay-as-you go.** With the pay-as-you-go option, you must continue to pay Premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but you are required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.
c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds "catch-up" amounts from your pay upon your return.

Upon return from such leave that has been or is being paid for under one of the methods referred to above, you will be permitted to re-enter the Plan on the same basis as you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

If your coverage in these Benefits terminates, due to your revocation of the Benefit while on leave or due to your non-payment of contributions, your coverage will be reinstated for the remaining portion of the Plan Year upon your return. However, for the Healthcare Flexible Spending Account, if your coverage terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, two options will be offered upon your return:

a) **Proration.** The actual amounts contributed by you would remain available for your use the duration of the Plan Year, but the expenses you incur during that lapse in coverage would not be reimbursable and your maximum contribution amount would be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900; or
b) **Reinstatement.** You may elect to reinstate the level of coverage in effect when the leave began, with your maximum contribution level remaining the same as previously elected. Any deficiencies in contributions will be made up when you return based on a payment schedule that is established by your employer. You will not, however, be entitled to receive reimbursement of any expenses that you incur during any previous lapse in coverage.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

10. How does the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect this Plan?

If you are going into or returning from military service, you may have special rights to healthcare coverage under your Healthcare Flexible Spending Account, pursuant to USERRA. These rights can include extended healthcare coverage. If this law may affect you, ask your Administrator for further details.

11. What happens if I don't spend all Plan contributions?

With respect to other Benefit options, subject to the applicable filing deadlines discussed in Article V, any contributed monies left at the end of the Plan Year will be forfeited. Having said this, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However if your Plan has adopted a Claims Extension Period (also known as an extended Grace Period) as further described within Section IX below, you have the additional period specified within Section I, General Information, to incur claims for you or your Dependents and still receive reimbursement for the Prior Year under the Plan.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully before the Plan Year begins. You want to be as certain as possible that the amount you decide to place in your accounts will be used entirely. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of

coverage in which the qualifying expense was incurred will be forfeited to the Employer. Plan benefit surplus will be administered under the guidelines of Section I, General Information.

In addition to the general rule above, you may also have limited opportunity to rollover any unused amounts in your Healthcare Flexible Spending Account to a Health Savings Account if otherwise permitted by the Plan. More information about the payment of reimbursable expenses, payments or allowable rollovers of any other distributions is further discussed in Section V.

V - BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire (salary) compensation in cash or use a portion to pay for certain other benefits or expenses during the year. The benefits or expenses that are available for payment under the Plan have been selected by your Employer and are identified under Section I, General Information, referring to the Plan of Benefit Options. Notwithstanding the individual benefit selections that are available to you under your Plan, a discussion of pertinent issues that impact some of the more common benefit alternatives follows:

Premium Only Account:

A Premium Only Account allows you to use tax-free dollars to pay for certain Premium Expenses under various Insurance Programs that we offer you. Premiums may include Employer sponsored benefits in addition to other benefits that are paid for as a reduction in your salary on a pre-tax basis. Premiums are paid on your behalf by your Employer. Please refer to Section I, General Information for information on Insurance Programs for which Premiums may be paid for by the Plan.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any Insurance Contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, you insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after 1) you have provided the Administrator the necessary information to apply for insurance, and 2) the insurance is in effect for you.

Premium Expense Flexible Spending Account:

A Premium Expense Flexible Spending Account allows you to use tax-free dollars to pay for certain Premium Expenses under various Insurance Programs that we offer you. Please refer to Section I, General Information, Plan of Benefit Options, for information on Insurance Programs for which Premium Expenses can be paid for by our Plan.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply. The Premiums under this plan will be paid by you and reimbursed to your from your spending account.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any Insurance Contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after 1) you have provided the Administrator the necessary information to apply for insurance, and 2) the insurance is in effect for you.

Healthcare Flexible Spending Account:

The Healthcare Flexible Spending Account enables you to pay for expenses that are not covered by our health plan(s) and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, and your dependents. A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when you are formally billed for, or are charged or, or pay for the medical care. The medical expenses, including any expense for medical care, which qualify are those permitted by Section 213(d) and Section 105 of the Internal Revenue Code and the rulings and Treasury regulations thereunder. A list of covered expenses is available from the Administrator. (Please note that these covered expenses may now also include the payment for certain over-the-counter medications.) You may not, however, be reimbursed for the cost of other healthcare coverage maintained outside of the Plan, or for long-term care insurance coverage or expenses.

Please refer to Section I, General Information for the maximum amount that you can contribute to your Healthcare Flexible Spending Account each Plan Year. In order to be reimbursed for a healthcare expense, you must submit your claim in the manner set forth under Section VI below. Reimbursement from the Plan will generally be paid no later than 30 days after receipt by the Administrator of a reimbursement claim.

Dependent Care Assistance Flexible Spending Account:

The Dependent Care Assistance Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time instead of being gainfully employed (but note the income limitations discussed below). Single employees can also use the account, subject to the applicable dollar limitations specified below.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements which qualify for expense reimbursement include:

a) A Dependent (Day) Care center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable State and local laws.
b) An Educational Institution for pre-school children. For children beyond pre-school age, only expenses for non-school care (e.g., after-care) are eligible.
c) An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal income tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: 1) $5,000 (if you are married, filing a joint return or you are head of a household) or $2,500 (if you are single or married, but filing separate returns); 2) your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of self-care has a monthly earned income of $250 for one dependent or $500 for two or more dependents) or such other amounts otherwise set forth and described under Section I, General Information.

Also, in order to have reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan.

You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you. Even if you do not take the Federal tax credit you will still be required to complete Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses" with your annual tax return.

VI - BENEFIT PAYMENTS

1. How do I request reimbursements from my account?

During the course of the Plan Year, you may submit requests for reimbursement of expenses that you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when they are paid. The Administrator will provide you with forms, or other online claim processing instructions, for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a

reimbursement, which is payment, soon thereafter. Remember, reimbursements that are made from the Plan are generally not subject to Federal income tax or withholding. Nor are they subject to Social Security taxes. Also note that you must submit all requests for reimbursement of any health care within the timely filing requirements defined in Section I, General Information. Dependent care request for reimbursement must be filed within the timely filing requirements defined in Section I, General Information. Requests for payment of insured benefits should be made directly to the Insurer. The provisions of the insurance policies will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Assistance Plan to the extent that there are sufficient funds in the applicable accounts to cover your request.

2. How are benefits paid to me?

The Administrator will make any and all payments or other reimbursements to you as soon as administratively feasible or as otherwise set forth herein and will be distributed in the manner elected by your Employer (including direct reimbursement by check, automatic deposit via automated clearing house (ACH)).

If any Benefit payment has been made but is not deemed to be a qualifying expense reimbursement, the Administrator will ensure that proper correction procedures are maintained with respect to the improper payment(s):

a) Upon identification of any improper payment, the Administrator will require you to pay back to the Plan an amount equal to the improper payment;
b) If you do not immediately repay the Plan, the Administrator will ensure that the proper amount is withheld from your wages or other compensation (with such amounts then being immediately remitted to the Plan by your Employer) to the extent consistent with applicable law;
c) To the extent that neither a) or b) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to you as part of your agreement.
d) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to your account until the indebtedness is repaid by you. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan.

Under all circumstances, you must agree that payment for qualifying Benefit expenses can only be made on behalf of you, your spouse or other qualifying dependents and is otherwise limited to the maximum dollar of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth herein.

3. What happens if I terminate employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
b) You will still be able to request reimbursement for qualified expenses from the contribution balance remaining in your Dependent Care Assistance Flexible Spending Account at the time of termination of employment. These expenses must be incurred prior to your leaving employment and filed within the timely filing requirements set forth for an employee leaving employment. Refer to Section I, General Information for guidelines of timely filing for terminating employees. However, no further salary redirection or Employer contributions will be made on your behalf after you terminate.
c) You may elect to continue your participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year subject to current COBRA provisions (including applicable provisions that may reduce or eliminate your ability to maintain COBRA eligibility). Please refer to the initial COBRA notification in Attachment A for additional information. The Plan Administrator will notify you as to your COBRA eligibility (if any) at the time of your qualifying event.
    1) If you elect to continue your participation in the Healthcare Flexible Spending Account, you must continue to make any required contributions to the Plan at the same level you had prior to your termination. Depending on the elections made by your Employer, you may be able to continue making such contributions on a pre-tax basis if you continue to receive compensation after your termination from employment. Otherwise, your contributions would be required on an after-tax basis only.
    2) If you elect not to continue participation in the Healthcare Flexible Spending Account, participation will cease and no further salary redirection and Employer contributions will be made on your behalf.
    3) If your participation in the Healthcare Flexible Spending Account ceases, you will be able to submit claims for healthcare expenses incurred prior to your date of termination provided the expenses are submitted within the timely filing limitations specified in Section I, General Information.

4. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced. That is because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VII - HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to Highly Compensated Employees?

Under the Internal Revenue Code, "Highly Compensated Employees" and "Key Employees" generally are Participants who are officers, shareholders, or highly paid employees. You will be notified by the Administrator each Plan Year whether you are a "Highly Compensated Employee" or a "Key Employee."

If you are within these categories, the amount of contributions and benefits paid for you under this Plan may be limited so that the Plan, as a whole, does not unfairly favor those who are highly paid, their spouses, or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the Key Employees if they, as a group, receive more than 25 percent of all of the nontaxable benefits provided for under our Plan.

Your own circumstances will dictate whether contribution limitations on "Highly Compensated Employees" or "Key Employees" will apply. You will be notified of these limitations if you are affected.

VIII - PLAN ACCOUNTING

The Administrator will make available to you a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember that you want to spend all of the money you have designated for a particular benefit by the end of the Plan Year.

IX - ADDITIONAL PLAN INFORMATION

1. Your rights under ERISA

Plan participants, eligible employees, and all other employees of the Employer are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that participants, eligible employees, and all other employees are entitled to:

a) Examine, without charge, at the Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

b) Obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other plan participants.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit 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 your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 (or such greater amount as determined by the U.S. Department of Labor) 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.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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

2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later the required grace period and timely filing limitations referred to in Section I, General Information. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) The reasons for the denial;
b) Reference to the specific provisions of the Plan on which the denial was based;
c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
d) A description of the Plan's review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary will have 180 days following the receipt of any notification of claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records, or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the claim, without deference to the initial denial and after taking into account all comments, information, documents, records, and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 30 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

3. Claims incurred during the "Claims Extension Period"

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include, but is not limited to payment from, health care reimbursement accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year. The provision for the "Claims Extension Period" under the Plan is identified under Section I, General Information. Please refer to Section I, General Information to determine if this provision applies to your Plan.

a) Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date of this amendment, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year with amounts remaining in the participant's applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.
b) Claims Extension Period—Defined. For purposes of these rules, the "Claims Extension Period" for Healthcare Flexible Spending Account shall be administered subject to the Adoption Agreement and Section I, General Information. Please refer to Section I for specific guidelines. For purposes of these rules, the "Claims Extension Period" for Dependent Care Assistance Spending Account shall be administered subject to the Adoption Agreement and Section I, General Information. The Employer has the discretion to establish a separate and unique Claim Extension Period for Healthcare Flexible Spending Account and Dependent Care Assistance Flexible Spending Account.
c) Order of Expense or Benefit Payment. Amounts remaining in the participant's applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully

utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant's dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).

d) Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing of all allowable claims submitted during the Claims Extension Period, pursuant to Section 1 above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein. Benefit surplus shall be administered as directed in the Adoption Agreement and Section I, General Information.

e) Claims Submission Deadline. All Healthcare Flexible Spending Account and Dependent Care Assistance Flexible Spending Account claims reimbursement requests must be submitted within the guidelines in the Adoption Agreement and Section I, General Information. All claims must be incurred within the Plan Year and Claims Extension Period, if applicable.

4. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 ("HIPAA"), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to Participants in those plans. HIPAA applies to the Plan Year of this Plan.

Protected Health Information or "PHI" is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan's documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of Eligible Employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Plan Administrator
- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI as well as the use and safeguarding of electronic PHI that is otherwise subject to applicable HIPAA Security guidelines as well. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures. A copy of this notice is also attached as Attachment B.

X - SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. Our Flexible Benefits Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator listed under Section I, General Information.

Attachment A

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

Please refer to the General Information to determine whether Special COBRA rules or Regular COBRA rules apply to this Health FSA Plan.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becomes entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

You may elect to continue participation in the Plan in accordance with proposed IRS regulations. However, unless the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") applies to your Plan, the continuation coverage will be offered until the end of the Plan Year in which the qualifying event occurs. COBRA continuation coverage generally will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:

a) The Healthcare Reimbursement Account has a deficit at the time of the qualifying event. If, taking into account all claims submitted on or before the date of the qualifying event, your remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year.

b) COBRA continuation will not be offered to a Healthcare Flexible Spending Account Participant in any Plan Year following the Plan Year in which the qualifying event occurs if:

   1) The Healthcare Flexible Spending Account is Exempt from HIPAA. The Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the salary redirection or, if greater, the salary redirection plus $500; and

   2) For the Plan Year in which the qualifying event occurs, the maximum amount you could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum benefit available to you for the Plan Year.

However, your Employer may choose to offer COBRA continuation coverage, notwithstanding the exceptions detailed above. If your Employer chooses to provide such additional COBRA continuation

coverage, you will be provided with additional information about any other rights you may also have at that time.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Please refer to Section I, General Information of this document for your Plan Administrator's name and address.

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice of any such disability, along with copies of any such written determination received from the Social Security Administration and the date it was received, to: [Name of the appropriate party to whom notice must be sent]. This information must be received by the applicable Plan representatives no less than 30 days before the end of the 18-month continuation coverage period.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep your Plan Administrator informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For more information about the Plan and your rights thereunder, contact the Plan Administrator listed under Section I, General Information.

Attachment B

****HIPAA NOTICE OF PRIVACY PRACTICES****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose:

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information:

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger,

sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Requirements:

We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact the Plan Administrator listed under Section I, General Information.

Filing a Complaint:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.