Toyoda Gosei North America Corporation & Affiliates Flexible Benefits Plan
Summary Plan Description
Amended and Restated
January 1, 2024

Introduction

Toyoda Gosei North America Corporation (the Employer) sponsors the Toyoda Gosei North America Corporation & Affiliates Flexible Benefits Plan (the Cafeteria Plan) that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. (Such plans are also known as cafeteria plans.)

This Summary describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan Documents and this Summary, then the Cafeteria Plan Document (including any amendments) will control.

Plan Components Offered

☒ Health Flexible Spending Arrangement (Health FSA) Component
  ☒ Grace Period

☒ Limited (Vision/Dental/Preventive Care) Health FSA Component
  ☒ Grace Period

☒ Dependent Care Assistance Program (DCAP) Component
  ☒ Grace Period

☒ Premium Payment Component
  ☒ Group Health Insurance
  ☒ Group Dental Insurance
  ☒ Group Vision Insurance

☒ Health Savings Account (HSA) Component

Specific Plan Provisions

General Plan Information

- Plan Name: Toyoda Gosei North America Corporation & Affiliates Flexible Benefits Plan

- Effective Date: January 1, 2024
- Plan Year: The 12-month period beginning on January 1

Plan Number

- 501

Plan Sponsor

- Toyoda Gosei North America Corporation
  1400 Stephenson Highway
  Troy MI 48083
  (248) 280-2100
- Federal employer tax identification number (EIN): 38-3467216

Plan Administrator

- Toyoda Gosei North America Corporation
  1400 Stephenson Highway
  Troy MI 48083
  (248) 280-2100

Agent for Service of Legal Process

- Toyoda Gosei North America Corporation
  1400 Stephenson Highway
  Troy MI 48083

Third-Party Administrator Information

- Forma Inc.
  http://www.joinforma.com

Run-Out Period for Health FSA, Limited (Vision/Dental/Preventive Care) Health FSA, and DCAP

- 90 days after the end of the Plan Year

Plan Eligibility

- Active, full-time employees with an average weekly schedule of 30 hours or more are eligible to participate in the Plan

Plan Waiting Period

- 30 days

Plan Entry Date

- First of the month following satisfaction of the Plan Waiting Period

Run-Out Period for Terminated Employees

- 90 days after termination of active coverage

Health FSA and Limited Purpose FSA Maximum Employee Contribution Limit

- $3,050 for the 2023 plan year

  Note: The annual maximum contribution limit to the Health FSA and Limited Purpose FSA is indexed annually to account for cost-of-living adjustments. The Plan's maximum employee contribution limit in future Plan Years will be the indexed limit announced annually by the IRS.

Dependent Care FSA Maximum Plan Reimbursement

- $5,000 for single employees or married employees filing taxes jointly
  $2,500 for married employees filing taxes separately

General Plan Provisions

Q-1. How do employees pay for benefits on a pre-tax basis?

An Employee's election to pay for benefits on a pre-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer. Under that Agreement, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following components:

- *Health Flexible Spending Arrangement (Health FSA) Component*-permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits. As described in Q-22, the Health FSA election may be for:
  - General-Purpose Health FSA Coverage; or
  - Limited (Vision/Dental/Preventive Care) Health FSA Coverage.
- *Health Savings Account (HSA) Component*-permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian. Benefits provided under the HSA, which consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis (see Q-28), are called HSA Benefits.
- *Dependent Care Assistance Program (DCAP) Component*-also called a dependent care flexible spending account-permits an Employee to pay for his or her qualifying Dependent Care Expenses

(as described in Q-41) with pre-tax dollars. Benefits provided under the DCAP are called DCAP Benefits.

- *Premium Payment Component* -permits an Employee to pay for his or her share of contributions for the Premium Payment Benefits with pre-tax dollars.

  Benefits provided generally under the Premium Payment Component are called Premium Payment Benefits.

For purposes of the Premium Payment Benefits, the terms Spouse and Dependent are defined as provided in the Premium Payment Benefits documents. For purposes of the other benefits, Spouse means a person of the same or opposite sex to whom you are legally married and who is treated as a spouse for federal tax purposes. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. If you have questions about whether an individual qualifies as a spouse or dependent, contract your Plan Administrator.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Q-3. Who can participate in the Cafeteria Plan?

Employees who are eligible for the Premium Payment Benefits are eligible to participate in the Cafeteria Plan, provided that the election procedures in Q-5 are followed. Eligibility for HSA Benefits also requires that you be an HSA-Eligible Individual. See Q-28 for additional information.

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

Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. How much an employee actually saves will depend on what family members are covered and the

contributions for the coverage, the total family income, and the tax deductions and credits claimed. There may be state tax savings, too.

Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements described in the Specific Plan Provisions, you become a Participant by completing an individual Election Form/Salary Reduction Agreement. You must complete the Election Form/Salary Reduction Agreement within the time period specified in the enrollment materials. An eligible Employee who fails to complete the Election Form/Salary Reduction Agreement as required will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a Change in Election Event occurs, as explained in Q-7).

Employees who participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for Health Plan Benefits, and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See Q-12 and Attachment 1 (found at the end of this Summary).

See Q-8, Q-12, and Attachment 2 (found at the end of this Summary) for information about how termination of participation affects your Benefits.

Q-6. What is the Significance of the Open Enrollment Period?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Cafeteria Plan by completing an Election Form/Salary Reduction Agreement. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period by the Employer.

Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

With the exception of HSA Benefits (for which prospective election changes generally are allowable), you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). You can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various Change in Election Events that are described in Attachment 1 (found at the end of this Summary).

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal

Revenue Code (the Code), if necessary, to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding any amounts due from your compensation.

Q-8. What happens if my employment ends during the Plan Year, or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for Health Plan Benefits, Health FSA Benefits, HSA Benefits, or DCAP Benefits. The Premium Payment Benefits will terminate as of the date(s) specified in the Premium Payment Plan. See Q-12, Attachment 2 (found at the end of this Summary), and the booklets for the Health Plan for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-24. For reimbursement of expenses from the DCAP Account after termination of employment, see Q-43. For information about obtaining distributions from your HSA at any time, including after termination of employment, contact the trustee/custodian of your HSA established and maintained outside of the Plan.

For purposes of pre-taxing COBRA coverage for Health Plan Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See Q-12 and Attachment 1 (found at the end of this Summary).

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

Q-9. Will I pay any administrative costs under the Cafeteria Plan?

No. The cost is paid in part by the use of forfeitures, if any (see Q-26 and Q-45). The rest of the cost of administering the Cafeteria Plan is paid entirely by the Employer. A separate HSA trustee/custodial fee may be deducted from your HSA account balance by your HSA trustee.

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

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future

changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

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

Premium Payment Benefits. The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the plan). For more information about how to file a claim and for details regarding the Premium Payment Benefits Plan insurance companies' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Premium Payment Benefits Plan.

HSA Claims Not Involving Issues Relating to Salary Reductions. Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Claims Under the Cafeteria Plan, Health FSA, or DCAP. If a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or you are denied a benefit under the Cafeteria Plan (such as the ability to pay for Health Plan, Health FSA, HSA, or DCAP Benefits on a pre-tax basis) due to an issue germane to your coverage under the Cafeteria Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Third-Party Administrator within 30 days after the date the Third-Party Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Third-Party Administrator, including in cases where a claim is incomplete. The Third-Party Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Third-Party Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Third-Party Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim under the Cafeteria Plan, Health FSA, or DCAP is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Third-Party Administrator that acts on behalf of the Plan Administrator with respect to appeals. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Appeals under the Cafeteria Plan, Health FSA, or DCAP will be reviewed and decided by the Third-Party Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Third-Party Administrator receives your request for review. The Third-Party Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision

on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

- a statement of your right to bring suit under ERISA §502(a) (where applicable).

Limitations Period for Filing Suit. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Cafeteria Plan, Health FSA, or DCAP must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Q-12. What is Continuation Coverage, and how does it work?

COBRA. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." See Attachment 2 (found at the end of this Summary) regarding COBRA coverage under the Health FSA Component, including when it may become available to you and your family and what you need to do to protect the right to receive it. See the booklets for the Health Plan for information about COBRA continuation coverage under those plans. Note also that for purposes of pre-taxing COBRA coverage, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods-see Attachment 1 (found at the end of this Summary).

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

Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Health Plan Benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt

to continue coverage). Your Employer may require you to continue all Health Plan Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Health Plan Benefits and Health FSA Benefits, the Plan Administrator may permit you to pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by prepaying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to prepay in advance, you must make a special election before such compensation normally would be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Health Plan Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health Plan Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for nonpayment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be prepaid before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see Attachment 1 found at the end of this Summary).

Premium Payment Component

Q-15. What are Premium Payment Benefits?

As described in Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Premium Payment Benefits with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4.

Q-16. How are my Premium Payment Benefits paid?

As described in Q-1 and in Q-15, if you select Premium Payment Benefits described in Q-15, then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Health FSA Component

Q-17. What are Health FSA Benefits?

As described in Q-2, a Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Health Plan).

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4 for an example dealing with pre-tax payment of Health Plan contributions.

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

Q-18. What is my Health FSA Account?

If you elect Health FSA Benefits, then an account called a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

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

(a) General-Purpose Health FSA Coverage; or

(b) Limited (Vision/Dental/Preventive Care) Health FSA Coverage.

Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. If you elect the General-Purpose Health FSA Coverage Option, your Spouse (if you are married) and your Dependents will also be ineligible to make HSA contributions. Also see Q-20 regarding the impact of carryovers on HSA eligibility.

Q-19. What are the maximum and minimum Health FSA Benefits that I may elect, and how are these benefits paid for?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health

FSA, subject to a minimum amount communicated by the Employer and a maximum amount of $3,050 per Plan Year, as adjusted for inflation in subsequent Plan Years. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

> *Example:* Assume that for the Plan Year, you have elected to be reimbursed up to $1,000 for Medical Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of $1,000 during the Plan Year. If you are paid biweekly, then your Health FSA Account would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

Q-20. Are health FSA carryovers a feature of the Plan?

No, health FSA carryovers are not a feature of the Plan.

Q-21. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any (see Q-20).

> *Example:* Suppose that for a calendar plan year, you elected $1,000 of coverage and contributed to your Health FSA Account (as described in Q-20) during January and February-that means that by February 23 you would have contributed $153.84 ($38.46 multiplied by 4 pay periods). On February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at

that point.

You may also be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. (See Q-23.)

Note that only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA Account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code §213(d). (See Q-22.) Stockpiling is not permitted.

Q-22. What are Medical Care Expenses that may be reimbursed from the Health FSA?

Your Health FSA election may be for only one of the following:

- General-Purpose Health FSA Coverage; or
- Limited (Vision/Dental/Preventive Care) Health FSA Coverage.

Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. See also Q-20 regarding the impact of carryovers on HSA eligibility.

The eligible Medical Care Expenses vary according to the type of Health FSA coverage option that is elected, as described below.

(a) *General-Purpose Health FSA Coverage Option.* For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d) (including expenses for menstrual care products). However, as described above, only reasonable quantities of OTC drugs will be reimbursed from your Health FSA Account in a single calendar month. The following list shows certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under IRS rules governing Health FSAs.

EXCLUSIONS:

- health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Health Plan);
- long-term care services;
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease ("cosmetic surgery" means

any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease);

- the salary expenses of a nurse to care for a healthy newborn at home;
- funeral and burial expenses;
- household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
- custodial care;
- costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- bottled water;
- cosmetics, toiletries, toothpaste, etc.;
- uniforms or special clothing, such as maternity clothing;
- automobile insurance premiums;
- transportation expenses of any sort, including transportation expenses to receive medical care;
- marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- any item that doesn't constitute "medical care" under Code §213(d); and
- any item that isn't reimbursable under applicable regulations.

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

FSA. And Health FSAs may reimburse OTC drugs if they qualify as medical care under Code §213(d), but they are still not deductible under Code §§213(a) and 213(b).

Ask the Third-Party Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Third-Party Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

(b) *Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option.* According to rules in Code §223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses Medical Care Expenses as described under the General-Purpose Health FSA Option (see subsection (a) above). You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the Medical Care Expenses listed below:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums); or
- Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code §223(c)(2)(C). This may include prescribed drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking-cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

Q-23. When must the Medical Care Expenses be incurred for the Health FSA?

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for a Plan Year, they must have been incurred during that Plan Year. In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin on the first day following the end of the Plan Year and will end 2 months and 15 days later.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. You may not be reimbursed for any expenses incurred before the Health FSA or the Cafeteria Plan became effective, before your Election Form/Salary Reduction Agreement became effective, or after a separation from service (except for continuation coverage, as described in Q-

12 and Attachment 2, found at the end of this Summary). Expenses incurred during a subsequent Plan Year can only be reimbursed from your Health FSA Account for that Plan Year.

> *Example:* If you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

In order to take advantage of the grace period, you must be a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates. See Q-24 regarding certain rules that apply to claims for reimbursement for Medical Care Expenses that are incurred during a grace period.

Note that the Health FSA cannot offer both the carryover and the grace period. See the "Plan Components Offered" section at the beginning of this Summary for the specific features offered by your Health FSA.

Q-24. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

When you incur an expense that is eligible for payment, you must submit a claim to the Third-Party Administrator. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see Q-11). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until the end of the Run-Out Period in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See Q-11.)

The following additional rules will apply to a Health FSA that offers the grace period feature:

- Medical Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. *Example:* Assume that $100 remains in your Health FSA Account at the end of a 2022 calendar plan year and that you have also elected $2,400 of Health FSA coverage for 2023. If you submit a $200 Medical Care Expense that was incurred in January 2023, $100 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2022 plan year. The remaining $100 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2023 plan year.
- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For this reason, if you also have Health FSA coverage for the new year, you may want to wait to submit Medical Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- *Example:* Using the same facts as in the previous example, assume that a few days after being reimbursed for the $200 grace period expense, you discover $100 of 2022 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2022 expenses. The Plan will not reprocess the $200 grace period expense so as to pay it entirely from your 2023 Health FSA amounts.
- Expenses incurred during a grace period must be submitted by the end of the Run-Out Period to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, the end of the Run-Out Period is also the deadline for submitting any claims for reimbursement of Medical Care Expenses incurred during the preceding Plan Year.)

Note that the Health FSA cannot offer both the carryover and the grace period. See the "Plan Components Offered" section at the beginning of this Summary for the specific features offered by your Health FSA.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer or Third-Party Administrator about what you must do to obtain reimbursement if such a system is implemented.

Q-25. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?

Yes. If the Medical Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period-see Q-23) are less than the annual amount that you elected for Health FSA Benefits (increased by any carryovers from the previous Plan Year, if applicable), you will forfeit any amounts that are not eligible for carryover to the following Plan Year as provided in Q-20. This is called the use-or-lose rule under applicable tax laws. The difference between what you elected (increased by any carryovers from the previous Plan Year, if applicable) and the Medical Care Expenses that were reimbursed will be forfeited at the end of the time limits described in Q-26 to the extent not carried over as provided in Q-20.

Q-26. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by the end of the Run-Out Period for which the election was effective or carried over as provided in Q-20 (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date-see Q-24). Forfeited amounts may be used as follows: to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; to reduce the cost of administering the Health FSA during the Plan Year and the subsequent Plan Year; and/or to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable law or IRS guidance. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Q-27. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit.

> *Example:* To qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Medical Care Expenses submitted for reimbursement or withhold the amount from your pay.

HSA Component

Q-28. What are HSA Benefits?

As described in Q-2, the HSA Component permits Employees to make pre-tax contributions to HSAs that Employees establish and maintain outside the Plan with an HSA trustee/custodian. For purposes of this Cafeteria Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Cafeteria Plan.

As described in Q-1, if you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

To participate in the HSA Benefits, you must be an HSA-Eligible Individual. This means that you are eligible to contribute to an HSA under the requirements of Code §223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer. (High Deductible Health Plan means the high deductible health plan option offered by your Employer that is intended to qualify as a high deductible health plan under Code §223(c)(2), as described in materials provided separately to you by the Employer.) If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code §223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage-and you should be aware that coverage under a Spouse's plan, including a Spouse's health FSA, could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian, and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax Salary Reductions through the Employer's payroll system to your designated HSA trustee/custodian.

If you elect Health FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. See also Q-20 regarding the impact of carryovers on HSA eligibility.

In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

Q-29. What is my HSA?

An HSA is not an employer-sponsored employee benefit plan-it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code §223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. Your Employer will select the HSA provider to whom it will permit you to forward pre-tax Salary Reductions. The Employer's selection of an HSA trustees/custodian is for administrative simplification and is not an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary-Reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. Neither your HSA nor the HSA Component of this Plan that allows you to contribute to your HSA on a pre-tax basis is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Q-30. What are the maximum HSA Benefits that I may elect under the Cafeteria Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. ($3,650 for single and $7,300 for family are the statutory maximum amounts for 2022, as adjusted for inflation in subsequent years) An additional catch-up contribution of $1,000 may be made if you are age 55 or older (you must certify your age to your Employer).

In addition, the maximum annual contribution shall be:

(a) reduced by any matching (or other) Employer contribution made on your behalf (there are currently no such Employer contributions (other than pre-tax Salary Reductions) made under the Plan); and

(b) prorated for the number of months in which you are an HSA-Eligible Individual (as described in Q-28).

Note that if you are an HSA-Eligible Individual for only part of the year but you meet all of the requirements under Code §223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA

benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code §223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 20% penalty (exceptions apply in the event of death or disability).

Q-31. How are my HSA Benefits contributed under the Cafeteria Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to contribute for with your salary reduction. From then on, you make a contribution by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

> *Example:* Suppose that you have elected to contribute up to $1,000 per year for HSA Benefits and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of $1,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the HSA Benefits that you have elected.

As described in Q-29, your Employer has no authority or control over the funds deposited in your HSA.

Q-32. Will I be taxed on the HSA Benefits that I receive?

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Cafeteria Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other Benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA, see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). State income tax and payroll tax savings may vary. Consult a personal tax advisor for more information.

Q-33. Who can contribute to an HSA under the Cafeteria Plan?

Only Employees who are HSA-Eligible Individuals can participate in the HSA Benefits. As described in Q-28, an HSA-Eligible Individual means an individual who meets the eligibility requirements of Code §223, who has elected qualifying High Deductible Health Plan coverage offered by the Employer, and who has

not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

Q-34. Can I change my HSA Contribution under the Cafeteria Plan?

As described in Attachment 1 (found at the end of this Summary), you may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements. See Q-8.

Q-35. Where can I get more information on my HSA and its related tax consequences?

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

DCAP Component

Q-36. What are DCAP Benefits?

As described in Q-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP).

As described in Q-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by completing an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Q-37. What is my DCAP Account?

If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions for such benefits that you have paid during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not

funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-38. What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to a minimum amount established by the Third-Party Administrator and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in DCAP Benefits, you'll pay for the benefits with a $3,000 salary reduction).

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

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

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

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described in Q-41 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Q-39 How are my DCAP Benefits paid for under the Cafeteria Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal

portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

> *Example:* Suppose that you have elected to contribute $2,600 per year for Dependent Care Expenses. Your DCAP Account would be credited with a total of $2,600 by the end of the Plan Year. If you are paid biweekly, then your DCAP Account would reflect that you have paid $100 ($2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

Q-40. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

> *Example:* Using the example in Q-39, suppose that you incur $1,500 of Dependent Care Expenses by the end of March. At that time, your DCAP Account would only have been credited with $700 ($100 times 7 pay periods), so only $700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to receive the remaining $800 in Dependent Care Expenses until after you had contributed enough to your DCAP Account.

You may also be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. (See Q-42.)

Q-41. What are Dependent Care Expenses that may be reimbursed?

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

- Each person for whom you incur the expenses must be a Qualifying Individual-that is, he or she must be:
    - a person under age 13 who is your qualifying child under the Code (in general, the person

must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

- your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the child as a dependent. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center-that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis-the center must comply with all applicable state and local laws.
- The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person whom you (or your

Spouse) can claim as a dependent for federal income tax purposes. If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.

- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.
- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):

  - expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);

  - the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and

  - expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided-e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

For more information about what items are-and are not-deductible Dependent Care Expenses, consult IRS Publication 503 (Child and Dependent Care Expenses) under the heading "Tests to Claim the Credit." But use Publication 503 with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code §21 (the Dependent Care Tax Credit, discussed below), not to explain what is reimbursable under a DCAP. In fact, some of the statements in Publication 503 aren't correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit and what expenses are reimbursable under a DCAP. Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought (see Q-42).

Ask the Third-Party Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Third-Party Administrator is not providing tax or legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);
- the earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for more than one-half of such year), or (b) a full-time student); or
- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further in Q-38.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is $5,000.

Q-42. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin on the first day following the end of the Plan Year and will end 2 months and 15 days later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred.

In order to take advantage of the grace period, you must be a Participant in the Plan with DCAP coverage that is in effect on the last day of the Plan Year to which the grace period relates. See Q-43 regarding certain rules that apply to claims for reimbursement for Dependent Care Expenses that are incurred during a grace period.

Q-43. What must I do to be reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Third-Party

Administrator through its paper or electronic DCAP Reimbursement Request Form. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see Q-11). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until the end of the Run-Out Period in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible (or during any applicable grace period); you can also be reimbursed for expenses incurred in the month following your termination of participation if such month is in the current Plan Year and your claim is submitted by the 90-day deadline. You will be notified in writing if any claim for benefits is denied. (See Q-11.)

The following additional rules will apply to Dependent Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

- Dependent Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. *Example:* Assume that $100 remains in your DCAP Account at the end of a 2022 calendar plan year and that you have also elected $2,400 of DCAP coverage for 2023. If you submit a $200 Dependent Care Expense that was incurred in January 2023, $100 of your claim will be paid out of the unused amounts remaining in your DCAP Account from the 2022 plan year. The remaining $100 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the 2023 plan year.
- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan

Year from which funds are taken to pay it. For this reason, if you also have DCAP coverage for the new year, you may want to wait to submit Dependent Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

- *Example:* Using the same facts as in the previous example, assume that a few days after being reimbursed for the $200 grace period expense, you discover $100 of 2022 Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2022 expenses. The Plan will not reprocess the $200 grace period expense so as to pay it entirely from your 2023 DCAP amounts.
- Expenses incurred during a grace period must be submitted by the end of the Run-Out Period to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, the end of the Run-Out Period is also the deadline for submitting any claims for reimbursement of Dependent Care Expenses incurred during the preceding Plan Year.)

Q-44. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period-see Q-42) are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account. (Carryovers are not available under the DCAP.) This is called the use-or-lose rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year or its grace period (if applicable), even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described in Q-45.

Q-45. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year by the end of the Run-Out Period for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within the Run-Out Period for Terminated Employees). Forfeited amounts may be used as follows: to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and/or to provide increased benefits or compensation to Participants in subsequent years in any

weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable law or IRS guidance. Also, any DCAP Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Q-46. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-38. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on IRS Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other Dependent Care Expenses submitted for reimbursement or withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Third-Party Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Third-Party Administrator is not providing tax or legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-47. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see Q-48).

> *Example:* If you elect $2,000 in coverage under the DCAP and are reimbursed $2,000, but you had Dependent Care Expenses totaling $4,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

Q-48. What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a

non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you.

The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account $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 ranges from a minimum of 20% of your qualifying expenses (producing a maximum credit of $600 for one Qualifying Individual or $1,200 for two or more Qualifying Individuals) to a maximum of 35% of such expenses (producing a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 (or fraction of $2,000) by which your adjusted gross income exceeds $15,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 (Child and Dependent Care Expenses). You may also wish to consult a tax advisor, as discussed below.

Q-49. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax-free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you. Consult a personal tax advisor for more information.

ERISA Rights

Q-50. What are my ERISA Rights?

The Cafeteria Plan and the HSA and DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Health Plan are governed by ERISA.

Note: This Summary Plan Description does not describe the Health Plan. Consult the Health Plan documents and the separate Summary Plan Descriptions for the Health Plan. This Summary Plan Description also does not describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

The Health FSA and DCAP Components are self-funded by the Employer and are contract administration

plans. The Third-Party Administrator processes claims for these Components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these Components. There is no trust for the Plan or any component.

The Health FSA Component is a group health plan subject to ERISA. The named fiduciary for the Health FSA Component is the Employer, its plan records are kept on the Plan Year basis, and its plan number is 501.

Your Rights

As a participant in the Cafeteria Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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 worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Employer, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue your Health Plan coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Employer, as Plan Administrator, to provide the materials and pay you up to $110 per 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 which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (see Q-11), 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.

Assistance With Your Questions

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

HIPAA Privacy Rights

Under HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies, including with regard to electronic PHI.

Additional General Information

Q-51. What other general information should I know?

This Q-51 contains certain general information that you may need to know about the Plan.

Qualified Medical Child Support Order

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

Amendment and Termination

Although the Employer intends to continue the Plan indefinitely, the Employer reserves the right to amend or terminate the Plan at any time and for any reason. If either of these actions is taken, you will be notified.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Health Plan and HSA Documents and Information

This Summary Plan Description does not describe the Health Plan. Consult the Health Plan documents and the separate Summary Plan Descriptions for the Health Plan for information about those plans. Neither does this Summary Plan Description describe many aspects of the HSA Component (e.g., with respect to claims and reimbursement under the HSA). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian for further HSA information.

Attachment 1

When Can I Change Elections Under the Cafeteria Plan During the Plan Year?

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of absence, including FMLA leave (defined in Q-14); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits-applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative-see Q-7. Note also that no changes can be made with respect to Health Plan Benefits if they are not permitted under the Health Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Health Plan). If the change involves a loss of your Spouse's or Dependent's eligibility for Health Plan Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

The Plan is designed to allow all plan changes permitted by the IRS Change in Election Event rules, including both Change in Election Events allowed under current laws and regulations and any subsequently approved Change in Election Events.

1. Leaves of Absence *(Applies to Health Plan Benefits, Health FSA, and DCAP Benefits).* You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. Change in Status *(Applies to Health Plan Benefits, Health FSA Benefits (as limited below), and DCAP Benefits).* 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 in item 3 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, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal

separation, or annulment);

- a change in the number of your 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 and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements *(Applies to Health Plan Benefits, Health FSA Benefits (as limited below), and DCAP Benefits).* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined in Q-41) for the dependent care tax exclusion).

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.

> *Example:* Assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status

Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year. (See also Q-20 and Q-21.)

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

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the Health Plan and Health FSA Benefits), a special rule governs which type 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's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election 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. However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See the Plan Administrator for more information. *Example:* Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

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

    - *DCAP Benefits*. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion. *Example:* Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

4. Special Enrollment Rights *(Applies Only to Major Medical Component of Health Plan Benefits).* In certain circumstances, enrollment for Health Plan Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Health Plan Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have.) When a special enrollment right explained in those separate documents applies to your Health Plan Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

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

provided for the child.

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

7. Change in Cost *(Applies to Health Plan Benefits, and DCAP Benefits (as limited below), but Not to Health FSA Benefits).* If the cost charged to you for your Health Plan Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your contributions;
- revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;
- drop your coverage, but only if no other benefit package option provides similar coverage.

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

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;
- if you are enrolled in another benefit package option (such as the HMO option under the Health Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Health Plan); or
- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

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

The Plan Administrator generally will notify you of increases or decreases in the cost of Health Plan

benefits; you generally will have to notify the Plan Administrator of increases or decreases in the cost of DCAP benefits.

The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage *(Applies to Health Plan Benefits and DCAP Benefits, but Not to Health FSA Benefits).* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Health Plan Benefits or DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Health Plan Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Health Plan Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Health Plan Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)
- *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other

cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

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

9. Reduction of Hours *(Applies to Only to Major Medical Component of Health Plan Benefits).* If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, you may prospectively revoke your election for Health Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Health Plan coverage is revoked.

10. Exchange Enrollment *(Applies to Only to Health Plan Benefits).* If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Health Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Health Plan coverage.

11. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

Attachment 2

COBRA Continuation Coverage Rights Under the Health FSA Component

Introduction

The following paragraphs generally explain COBRA coverage under the Health FSA Component, when it may become available to you and your family, and what you need to do to protect the right to receive it. The description of COBRA coverage contained in this Attachment applies only to the Health FSA Component of the Plan and not to any other benefits offered under the Plan or by the Employer. See the booklets for the Health Plan for information about COBRA continuation coverage under those plans.

What Is COBRA Coverage?

COBRA 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 below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA Coverage May Become Available to "Qualified Beneficiaries." After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA Coverage Under the Health FSA Component

COBRA Coverage Is Offered Only in Limited Circumstances. COBRA coverage under the Health FSA Component will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year; Carryover Rights. Participants with underspent accounts can receive Health FSA COBRA coverage only through the end of the plan year in which the COBRA qualifying event occurs.

All Qualified Beneficiaries Are Covered Together Under the Health FSA Unless Otherwise Elected. Unless

otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Employer for more information.

No Health FSA Open Enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying Events for the Covered Employee. If you are an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component 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.

Qualifying Events for the Covered Spouse. If you are the spouse of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component 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; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your coverage under the Health FSA Component in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or

- you stop being eligible for coverage under the Plan as a Dependent (see Q-2).

Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA). Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Health FSA Component during the leave. Contact the Employer for more information about these special rules.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage under the Health FSA Component to qualified beneficiaries. You need not notify the Employer of any of these qualifying events.

*You Must Notify the Plan Administrator of Certain Qualifying Events by This Deadline.*For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

*No COBRA Election Will Be Available Unless You Follow the Plan's Notice Procedures and Meet the Notice Deadline.*In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from the Employer at no charge), and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Employer during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Coverage

*How to Elect COBRA.*To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand-deliver it to the Employer. (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Employer.) You may provide the Election Form only by mail or hand-delivery. Delivery by another method, including by fax or email, is not acceptable.

*Deadline for COBRA Election.*If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED

ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent Election Rights. Each qualified beneficiary will have an independent right to elect COBRA. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Length of COBRA Coverage

COBRA coverage under the Health FSA Component is temporary and can last only until the end of the plan year in which the qualifying event occurred-see the section above entitled "COBRA Coverage Under the Health FSA Component."

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage under the Health FSA Component will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time; or
- the employer ceases to provide any group health plan for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the Plan (including both employee and any employer contributions but disregarding any carryovers from the previous plan year) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

Payment for COBRA Coverage

How Premium Payments Must Be Made. Unless you are able to continue eligibility in the Cafeteria Plan and pay your COBRA premiums on a pre-tax basis as described in Attachment 1, all COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When Premium Payments Are Considered to Be Made. If mailed, your payment is considered to have

been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage. If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly Payments for COBRA Coverage. After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage-it is your responsibility to pay your COBRA premiums on time).

Grace Periods for Monthly COBRA Premium Payments. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of

the month to make each monthly payment. Your COBRA coverage will be provided for each month so long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for reimbursement of a medical expense incurred while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption With the Covered Employee During a Period of COBRA Coverage. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs. A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Notice Procedures

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from the Employer without charge). Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail your notice to the administrator listed on the form. Delivery by another method, including by fax or email, is not acceptable unless specifically permitted on the form.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice period is described in the paragraph above entitled "You must notify the plan administrator of certain qualifying events by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/beneficiaries who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Who May Provide Notices

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.