The BESTflex℠ Plan

Summary Plan Description

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YOUR BESTFLEX PLAN

The BESTflex Plan is a cafeteria plan that is governed by the Internal Revenue Service (IRS) (Internal Revenue Code (IRC) Section 125) and provides you with an opportunity to receive certain benefits on a pre-tax basis, which means your contributions are exempt from most income and payroll taxes. However, your ability to receive these benefits on a tax-free basis could change under certain circumstances and is not guaranteed.

Your BESTflex Plan includes Flexible Spending Account (FSA) administration. When you enroll in an FSA, you choose your election amount for the plan year. Your FSA election is split among your pay periods and funds are deducted from your payroll on a pre-tax basis. The funds are deposited into your FSA and you use the funds to pay for eligible expenses.

About Employee Benefits Corporation

We work with your employer to offer you the BESTflex plan and provide you with service on the plan when you enroll in it. **We are not your insurance carrier.** We manage your employer's BESTflex Plan and process your claims associated with the eligible expenses you incur. Our website offers secure access to your account information with *My Account Assistant.*

If you have any questions about your plan options, visit us on our website, or contact us via email at participantservices@ebcflex.com or phone at (800) 346-2126.

ABOUT THIS DOCUMENT

This document covers the basic aspects of your BESTflex Plan and the associated administration. The *My Company Plan* accompanies this document, and together they provide a Summary Plan Description for your BESTflex Plan, to help you understand the specific benefits offered as part of your employer's plan. You will receive a copy of *My Company Plan* from your employer, or you can access it by logging into *My Account Assistant* from our website, www.ebcflex.com.

A complete *Plan Document* is available from your employer upon request.

My Company Plan contains:

- The plan's effective date
- Your plan year
- Eligibility definitions
- Details about your BESTflex Plan Options, explained below
- FSA contribution limits
- Optional features such as rollover, grace period, or employer contributions, if they apply
- Claim submission deadlines
- Contact information for the plan
- Legal information about the BESTflex Plan and component benefits

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HOW THE BESTFLEX PLAN AFFECTS OTHER BENEFITS, TAXES AND INSURANCE

Social Security Benefits

The BESTflex Plan generally reduces the amount of your wages used by the Social Security Administration to calculate your Social Security benefit. Consequently, your Social Security retirement or disability income may be less than it would have been had you not participated in the BESTflex Plan. For this reason, you may want to increase your retirement savings to offset the potential loss of Social Security benefits. If you are concerned, discuss it with your local Social Security Administration office or your financial advisor.

Your Tax Return

When you receive your W-2 statement at the end of the year, the amount of wages shown on the form is your total compensation minus any amounts withheld by your employer under the BESTflex Plan or other non-taxable benefits. You report these wages when you fill out your tax return. Your income tax is lower because it is based on a smaller gross taxable income.

Insurance Payments or Benefits

Any payments or benefits that you are entitled to receive from an insurance company, HMO or other provider of benefits are governed by the provider of those benefits and not by this plan.

Health Savings Account Eligibility

Your employer provides you with the opportunity to make pre-tax contributions to a Health Savings Account (HSA) through the BESTflex Plan. To establish and contribute to an HSA, you must be enrolled in a qualified high-deductible health plan (HDHP) and you cannot have any disqualifying health coverage. Some of your BESTflex Plan options may be disqualifying health coverage, so it's important to understand how your plan enrollment may affect your HSA eligibility.

Eligibility to Contribute to an HSA

To be eligible to contribute to an HSA during any month, you must:

- Be covered by an HDHP on the first day of that month. An HDHP is a health plan that meets statutory requirements for annual deductibles (other than for preventive care) and out-of-pocket expenses.
- Not be entitled to Medicare on the first day of that month.
- Not be claimed as a dependent on someone else's tax return for that year.
- Not be covered by any "disqualifying coverage." Refer to the next section for details on disqualifying coverage.

Your employer may establish an HSA for you and select an HSA administrator, or you may select and open your own HSA. You can establish more than one HSA and transfer funds between accounts.

Disqualifying Coverage

In general, disqualifying coverage is any coverage that pays for your medical expenses before a minimum deductible amount, set by law, is reached. That means almost any health plan that is not an HDHP will disqualify you from contributing to an HSA; however, dental, vision, disability, accident, and long-term care coverage are not considered disqualifying.

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Disqualifying coverage includes both benefits you elect and coverage you might have under a plan of another person, such as a spouse or parent.

If you (or your spouse, if you're married) intend to make an HSA contribution during your BESTflex plan year, you cannot elect a standard health FSA because it reimburses all medical expenses and is disqualifying coverage. You can elect a limited health FSA because it only reimburses eligible dental or vision expenses.

Examples of disqualifying health coverage include:

- **When you have another employer's health plan:** You will be disqualified from contributing to an HSA if you are covered under your spouse's employer's health plan and it is not an HDHP.
- **When you have a Health Care FSA:** You will be disqualified from contributing to an HSA if you are covered under a standard health FSA (a limited health FSA is permitted).

Health Care FSA Grace Period and HSA Compatibility

You will be ineligible to make HSA contributions until the first day of the month following the end of the prior plan year's grace period if you have a balance in your Health Care FSA on the last day of the prior plan year.

YOUR BESTFLEX PLAN OPTIONS

You can choose to participate in any of the BESTflex Plan accounts available under your employer's plan design, as long as you are eligible to participate in each account.

Once you elect to participate in the BESTflex Plan, you cannot cancel participation in the BESTflex Plan or change the amount of your payroll withholding during the plan year unless you experience certain events that permit election changes.

Thoughtful planning can minimize forfeiting unspent funds at the end of the plan year. Review the eligible expenses for the plan options for which you are enrolling and estimate the total amount you expect to spend for those expenses during the upcoming plan year. Based on this estimation, carefully decide the amount you want to contribute through your BESTflex Plan. The IRS prohibits returning unused dollars to you.

You are able to decline participation in the BESTflex Plan. If you decline participation, you are not able to enroll in the BESTflex Plan until the following plan year, unless you experience certain events that permit election changes.

Refer to the Permitted Election Change Events section for more information.

Group Insurance Premium Payments

Your employer may withhold money from your paycheck to pay for your medical or other group insurance premiums. Because you have the BESTflex Plan, these insurance premium expenses become an automatic, pre-tax deduction.

Cash-in-Lieu of Benefits

Your employer provides you with the opportunity to receive extra money for waiving certain group insurance benefits. This money is added to your paycheck as regular taxable income. Refer to *My Company Plan* for more information.

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Health Savings Accounts

Your employer provides you with the opportunity to set aside funds to be deposited into your HSA. Because you have the BESTflex Plan, these HSA contributions may be deducted pre-tax.

Dependent Care FSA

The Dependent Care FSA provides you with the opportunity to set aside pre-tax funds to pay for expenses incurred for the care of your child(ren) or other eligible dependents. You (and your spouse, if you are married) must be working, looking for work, or be a full-time student to use this account.

Refer to the Dependent Care FSA Details section for more information.

Health Care FSA

Your employer offers a **limited health FSA**. A limited health FSA is a health plan benefit that provides you with an opportunity to pay for certain eligible out-of-pocket vision and dental expenses on a pre-tax basis (governed by IRC 105 and 125).

You decide how much pre-tax money to put into this FSA, up to an annual limit. If you or your spouse contributes to a Health Savings Account (HSA), you may contribute to a HSA and a limited health FSA in the same plan year.

Refer to the Health Care FSA Details section for more information.

WHO CAN BE COVERED

Federal law determines who can be provided tax-favored coverage through the BESTflex Plan. Usually, this includes any person for whom you can claim a deduction on your personal tax return, explained further in the following sections. This could be a spouse, child, or other dependent, as long as that person is covered by a benefit included in the BESTflex Plan.

For purposes of your Health Care FSA, this means your spouse's expenses are eligible for reimbursement. In order for your spouse's expenses to be eligible for reimbursement from your Dependent Care FSA, however, your spouse must qualify as a dependent as described in the Dependent Definition for Dependent Care FSA section below.

Defining what constitutes a "dependent" or "child" varies depending on the type of benefit offered.

Dependent Definition for Group Health Plans

Certain group health plans, such as major medical plans, that offer dependent coverage are required to make coverage available to children of a covered employee until age 26. Although not required to, other health plans may allow children to remain on the plan for that same period. Refer to your individual plan's coverage booklets to determine if dependent coverage is provided through age 26. If the child is still receiving coverage at age 26, federal law allows the participant to receive tax-favored treatment on the coverage through end of the taxable year in which the child turned age 26. Your Health Care FSA allows a child to remain covered as a dependent through the end of the taxable year in which the child turns age 26.

A **child** for these purposes is someone who is one of the following:

- A son, daughter, stepson or stepdaughter of the taxpayer

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- An eligible foster child of the taxpayer
- A legally adopted child of the taxpayer

Dependent Definition for Health Plans Generally

For health plans that provide dependent coverage to more individuals than just the taxpayer's **child** as defined above, or for health plans that are not required, and have not chosen, to provide dependent coverage through age 26, the dependent must be either a **qualifying child** or a **qualifying relative** in order to receive tax-favored treatment:

A **qualifying child** is someone who, for any taxable year:

- Is a child, brother, sister, stepbrother or stepsister of the taxpayer, or a descendent of any such child or relative;
- Is not yet 19 (or is a student who is not yet 24) by the end of that calendar year, or is any age but permanently and totally disabled at any time during the year;
  Note: A "student" for this purpose is defined as a full-time student for at least five calendar months during the year.
- Has not provided more than half of his or her own support in that year; and
- Has the same principal place of abode as the taxpayer for more than half of that year.
  Note:
  - A child supported by a parent who lives with another relative (such as an aunt), is no longer a dependent of the taxpayer but could be a dependent of the relative
  - Temporary absences due to illness, education, military service, and similar factors do not result in loss of residency with the taxpayer. A child attending college away from home could have the same principal abode as the taxpayer in certain instances.

A **qualifying relative** is someone who, for any taxable year:

- Has a relationship to the taxpayer, either as:
  - A child (or a descendent of a child), brother, sister, stepbrother, stepsister, father, mother (or other ancestor), stepmother, stepfather, niece, nephew, aunt, uncle, or in-law (father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, or daughter-in-law), or
  - Another individual who has the same principal place of abode as the taxpayer and is a member of the taxpayer's household (unless the relationship violates local law);
- Receives half or more of his/her support in the year from the taxpayer; and
- Is not a **qualifying child** of any taxpayer in the year

Dependent Definition for Dependent Care FSAs

For purposes of allowing tax-favored reimbursements from a Dependent Care FSA for care of a dependent, the dependent must be a **qualifying individual**.

A **qualifying individual** is someone who, for any taxable year, is one of the following:

- A **qualifying child**, as defined above for purposes of excepted group health plans, who has not attained age 13 and who both:
  - Does not have his or her own dependents, and
  - Is not a **qualifying child** of any other taxpayer during the year

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- A spouse or other individual who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than half the year (unless the relationship violates local law)

Citizens or Nationals of Other Countries

An individual can be a dependent only if he or she is a U.S. citizen, a U.S. national, a U.S. resident or a resident of a country contiguous with the U.S. This rule does not apply to an adopted child of a U.S. citizen or U.S. national, if the child has the same principal place of abode as the taxpayer and is a member of the taxpayer's household.

Dependents in Cases of Divorce or Unmarried Parents

Special rules apply to determine which parent has a dependent child in the case of divorce, legal separation, or the parents living apart. In general, a child is a qualifying child of the custodial parent, defined as the parent with whom the child resides for the longest period of time or the greatest number of nights during the year.

Health Care FSA

In the case of a Health Care FSA, either the custodial or non-custodial parent may claim reimbursement for the expenses of a child if four requirements are met:

1. Parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written agreement or have lived apart at all times during the last six months of the calendar year
2. Over half the child's support during the year comes from one or both parents
3. The child is in the custody of one or both parents for over half of the year
4. The child is a **qualifying child** or **qualifying relative** of one of the parents

Dependent Care FSA

For purposes of a Dependent Care FSA, only the custodial parent with whom the child resides for the greatest number of nights may use this benefit. If the child resides with both parents for the same number of nights, the parent with the highest adjusted gross income may use this benefit.

DEPENDENT CARE FSA DETAILS

Dependent Care FSA Annual Elections

You decide how much pre-tax money to put into your Dependent Care FSA, up to an annual limit. The maximum amount you may elect is the lesser of an established maximum set by your employer or the annual statutory amount. Refer to *My Company Plan* for your plan's maximum election amount.

Your annual election amount is the total dollar amount you'll contribute to the FSA over the entire plan year. Your per paycheck amount is equal to your annual election divided by the number of paychecks in your plan year. Your employer withholds your per paycheck amount from each of your paychecks throughout the plan year.

You cannot cancel or change your election amounts during the plan year unless you experience a certain event for which the plan permits election changes.

Refer to the Permitted Election Change Events section for details.

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Funds Available as They are Deposited

You may only access your Dependent Care FSA funds as you deposit them. If you submit a reimbursement claim for an amount larger than your current balance, it will be paid out over time as your payroll deductions are deposited in your Dependent Care FSA. Your current Dependent Care FSA balance is the maximum reimbursement you can receive.

Expenses Eligible for Reimbursement

For dependent care expenses to be eligible for reimbursement from the Dependent Care FSA, they must be incurred to enable you (and your spouse, if you are married) to work, look for work, or attend school full-time. This means that if you take a leave of absence from work, you may not be able to be reimbursed for expenses incurred during the leave.

Eligible expenses must be incurred for care provided in or outside your home for:

- A **qualifying child** who is under the age of 13 and who depends on you (and your spouse, if you are married) for at least half of their support, does not have their own dependents, and is not a **qualifying child** of any other taxpayer during the year; or
- Your spouse or dependent (adult or child) who is mentally or physically incapable of caring for himself or herself and has the same principal place of abode, and spends at least 8 hours of each day in your house.

Note: You cannot take the Federal Tax Credit for dependent care expenses for amounts reimbursed out of this account.

Dependent Care Providers

To be an eligible dependent care expense, your dependent care provider:

- Cannot be your child who is under the age of 19, a person who you or your spouse could claim as a dependent for tax purposes, or a parent of the qualifying individual;
- Must provide their Taxpayer Identification Number (when they have one) or their SSN (for individuals who are providers); and
- Must comply with all state and local rules if the provider is a dependent care center that provides care to more than six individuals.

Incurring Eligible Expenses

An expense is incurred when the care has been provided, not when the expense is billed or paid. Expenses incurred before your plan effective date are not eligible.

If you pay for eligible dependent care expenses in advance of care and submit a claim, you will not be reimbursed until after the care has been provided.

Expenses Not Eligible for Reimbursement

Dependent expenses that are not eligible for reimbursement include:

- Educational expenses for Kindergarten and later grades
- Overnight camps
- Health care expenses
- Meals, supplies, and materials

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- Housecleaning and other services, unless they are a minor part of the primary job of providing care to a qualifying individual
- Expenses incurred while you (or your spouse) are out of work and not actively looking for work

Annual Limits

The Dependent Care FSA has the following annual contribution limits based on tax filing status:

- $5,000 maximum per calendar year for individuals who are single, head of household, or married filing jointly
- $2,500 maximum for individuals who are married and filing income taxes separately

In addition, you may not be reimbursed for more than the following reimbursement limits:

- **If you are single:** Your reimbursable limit is your net taxable pay (that is, your income after all pre-tax payroll deductions are taken) for the year in which the expenses are incurred.
- **If you are married and your spouse works:** Your reimbursable limit is the lesser of your net taxable pay (that is, your income after all pre-tax payroll deductions are taken) or your spouse's net taxable pay for the year in which the expenses are incurred.
- **If you are married and your spouse is a full time student or is physically or mentally incapable of caring for himself or herself:**
    - Your reimbursable limit is $250 in any one month if you have only one dependent, or
    - Your reimbursable limit is $500 in any one month if you have more than one dependent.

IRS Form 2441

You are required to report your BESTflex Plan dependent care pre-tax expenses and any federal tax credit for dependent care expenses on IRS Form 2441. This form is an attachment to your federal income tax return and it requires the name, address, and tax identification number of your dependent care provider. Contact your tax advisor if you have questions about this form. If your employer reports plan reimbursements rather than deductions on your W-2 and your Dependent Care FSA has a grace period, contact your financial advisor to discuss any possible tax implications.

HEALTH CARE FSA DETAILS

Your employer offers a **limited health FSA**.

Health Care FSA Annual Elections

You decide how much pre-tax money to put into your Health Care FSA, up to an annual limit. The maximum amount you may elect is the lesser of an established maximum set by your employer or the annual statutory amount. Refer to *My Company Plan* for your plan's maximum election amount.

Your annual election amount is the total dollar amount you'll contribute to the FSA over the entire plan year. Your per paycheck amount is equal to your annual election divided by the number of paychecks in your plan year. Your employer withholds your per paycheck amount from each of your paychecks throughout the plan year.

You cannot cancel or change your election amounts during the plan year unless you experience a certain event for which the plan permits election changes.

Refer to the Permitted Election Change Event section for details.

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Funds Available Right Away

You can spend money from your Health Care FSA anytime during the plan year, whether the entire amount has already been withheld from your paycheck or not. You can incur a large expense equaling your total annual election amount early in the plan year, be reimbursed soon after you incur it, and your remaining contribution amount is withheld from your paychecks throughout the plan year.

Expenses Eligible for Reimbursement or Payment

Your Health Care FSA reimburses expenses that the Internal Revenue Service classifies as eligible under Internal Revenue Code section 213. Section 213 defines expenses for "medical care" as amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Health club memberships, insurance premiums, or mattresses are not eligible for reimbursement even if they could meet the definition of "medical care." Otherwise, we reimburse you for all eligible expenses within the parameters of the regulations, which sometimes specify that additional information may be needed to verify an expense is eligible.

Limited Health FSA Eligible Expenses

Limited health FSA eligible expenses are for vision and dental care only. Refer to the *Limited FSA Eligible Expenses* document available on our website for a more detailed list.

Incurring Eligible Expenses

Other than orthodontia expenses explained below, an expense is incurred when the service takes place, not when the expense is billed or paid. Expenses incurred before your plan's effective date are not eligible.

If you pay for eligible expenses in advance and submit a claim, you will not be reimbursed until after the service has been provided.

Orthodontia

Special rules exist for reimbursement of orthodontia expenses. If you have entered into a payment plan arrangement with your provider, submit your payment plan to Employee Benefits Corporation and you will be reimbursed based on the schedule of and in the amounts stated in the payment plan. If the terms of your payments change, you will be asked to submit a new provider payment plan to Employee Benefits Corporation. Payments made before starting orthodontic treatment (down payments) can be reimbursed up to your available election limit as of the payment date, as long as you include proof of payment along with your claim.

Refer to the section on Submitting Claims for Reimbursement for more information about what must be included in your claim documentation.

Grace Period

Your employer's plan includes a grace period, which extends your plan year by 2 months and 15 days, giving you a total of 14 ½ months (the 12 month plan year plus the 2 ½ month grace period) to use your FSA contributions. With the grace period, you can use your FSA funds for eligible expenses you incur from the very beginning of the plan year through the entire grace period.

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During the grace period, you may have expenses eligible for reimbursement from two plan years – the old plan year and the new plan year. Payments and reimbursements are processed in the order they are received. In order to use funds from the old plan year to reimburse claims incurred during the grace period, claims must be submitted for reimbursement by the end of the old plan year's runout period. Refer to the section on Submitting Claims for Reimbursement for more detail.

Grace Period Eligibility

The grace period applies to all participants with an active plan on the last day of the plan year. A participant whose plan is not active on the last day of the plan year, such as a participant who ended their employment mid-plan year, is not eligible for the grace period.

Your Rights Under the Health Care FSA

COBRA Continuation

If your employer normally has at least 20 employees and is not a church-controlled entity, COBRA may apply to your Health Care FSA. If COBRA applies and you, your spouse, or your dependent lose coverage due to a qualifying event, then you, your spouse, or your dependent may elect to continue coverage, subject to the limitations described in the COBRA Continuation Coverage is Temporary section.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of your Health Care FSA plan when you would otherwise lose coverage because of a life event known as a COBRA qualifying event. Specific COBRA qualifying events are listed later in this document. COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary (QB). QBs are individuals who have the same rights as active employees on the group health plan. QBs are generally employees, employees' spouses and employees' dependents, who were covered by the group health plan on the day prior to a COBRA qualifying event. QBs are also children who are born to or adopted by the covered employee during the COBRA continuation period. These children must be added to the plan within 30 days of their birth or adoption. The newborn or adopted child may remain on the continuation coverage only for the maximum coverage period associated with the original qualifying event.

If you are an employee who is covered by your employer's Health Care FSA on the day prior to the event, you will become a qualified beneficiary if you lose your coverage under the FSA due to one of the following qualifying events:

- Your hours of employment are reduced, causing you to no longer be eligible for the Health Care FSA or causing your premium to increase for the same plan; or
- Your employment ends for any reason other than your gross misconduct.

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If you are the spouse of an employee who is covered by their employer's Health Care FSA on the day prior to the event, you will become a qualified beneficiary if you lose your coverage under the FSA because of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced, causing you to no longer be eligible for the same group health plan(s) or your premium to increase for the same group health plan(s);
- Your spouse's employment ends for any reason other than his/her gross misconduct;
- Your spouse becomes enrolled on Medicare Part A, Part B or both; or
- You become divorced or legally separated from your spouse.

If you are a covered employee and you drop your spouse from coverage in anticipation of divorce or other qualifying event before it actually happens, your ex-spouse must still be provided with COBRA notification. When the divorce or other qualifying event becomes final, the employer must be notified so the notification can be sent.

Your dependent children will become qualified beneficiaries if they were covered under the plan on the day prior to the event, and if they lose coverage under the plan as a result of any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours are reduced, causing the child to no longer be eligible for the same group health plan(s) or the child's premium to increase for the same group health plan(s);
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes enrolled in Medicare Part A, Part B or both;
- The parents become divorced or legally separated; or
- The child stops being eligible for the coverage under the plan as a "dependent child."

COBRA Continuation Coverage is Temporary

Generally, COBRA continuation coverage under your employer's Health Care FSA will only be available, if at all, until the end of the plan year in which a qualifying event occurs. This is because an exception under federal law limits COBRA continuation coverage for most Health Care FSAs. The exception applies to your employer's Health Care FSA if your employer does not make any contributions to your Health Care FSA, your Health Care FSA is a **limited health FSA**, or if contributions your employer makes are less than $500 or are limited to a matching amount to your contributions.

If this exception applies, and when a qualifying event occurs you have spent more out of your FSA than your employer could charge you for COBRA premiums for the rest of the plan year, your employer is not required to offer you COBRA continuation coverage for your Health Care FSA.

If your plan does not qualify for the exception noted above, COBRA continuation rules allow you to continue your coverage for 18 or 36 months (depending on the qualifying event), and you may be eligible for an extension of your coverage period if you experience a second qualifying event.

Notification of Qualifying Events and Paying for COBRA

COBRA continuation coverage will be offered to QBs only after the plan administrator (often your employer) has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction in hours of employment, the death of the employee, or enrollment of Medicare (Part A, Part B or both), your employer must notify the plan administrator of the qualifying

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event within 30 days of any of these events or within 30 days following the date on which coverage ends, if later.

For all other qualifying events, you must notify your employer within 60 days after the qualifying event occurs. Failure to notify your employer may result in Health Care FSA continuation coverage being unavailable.

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the QBs within 14 days. For each QB who elects COBRA continuation coverage, COBRA continuation coverage will begin:

- On the date of the qualifying event; or
- On the date the group health plan coverage would otherwise have been lost.

COBRA notices will be sent to the employee's last known address. Under the regulations, you have 60 days to elect coverage from the later of:

- The date you would lose coverage due to one of the above listed qualifying events; or
- The date the COBRA election notice is provided to you by the plan administrator/employer.

QBs who are incapacitated or die may have a legal representative, estate or spouse make the election. Elections are considered received on the date that they are mailed. The postmark on the envelope will be used as verification. If you do not choose continuation coverage on a timely basis (within 60 days), you will not be able to enroll in Health Care FSA continuation coverage.

If you choose continuation coverage, your employer is required to give you coverage that, at the time it is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. If your employer were to change its Health Care FSA in any way, your continuation coverage would also reflect the new changes.

Each QB in a family may make a separate, independent election. A separate election simply means that each QB can decide whether to elect or not elect coverage for themselves. Because a Health Care FSA covers expenses for an eligible employee, their spouse and eligible dependents, an election by any QB will allow coverage to continue for all of those individuals.

Under the regulations, your employer is allowed to charge you up to 102% of the monthly premium amount for your continuation coverage. The initial premium payment is due 45 days from the date of the COBRA continuation coverage election. Coverage will not be reinstated until payment has been made. Premiums are normally due on the first of the month and will be stated in your COBRA notification. There is a grace period of at least 30 days for payment of the regularly scheduled premium. Payment is considered made on the day it was mailed. Verification will be the postmark date on the envelope.

HEART Act Distributions

The Heroes Earnings and Relief Tax Act of 2008 (HEART Act) allows certain Health Care FSA Participants, known as Qualified Reservists, to elect a distribution of unused amounts from their Health Care FSA.

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If you are a Qualified Reservist, you may receive a Qualified Reservist Distribution from the balance of your Health Care FSA if:

- You are a member of a reserve component (as defined in 37 U.S. C. § 101) who is ordered or called to duty for a period of 180 days or more or for an indefinite period, and
- You make a request for distribution during the period beginning with your order or call to active duty and ending on the last day of the plan year, including the grace period, in which your order or call to active duty occurred.

The amount of the distribution from the Health Care FSA is limited to the payroll reduction amounts you have contributed at the time of the request, minus any reimbursements you have already received. You may only receive one Qualified Reservist Distribution per plan year. You may submit no further claims for reimbursement from your Health Care FSA after your distribution.

Your ERISA Rights

If your employer is covered by the Employee Retirement Income Security Act of 1974 (ERISA), then as a participant in the Health Care FSA, you have certain rights and protections under ERISA. See *My Company Plan* to determine your employer's ERISA status.

Statement of ERISA Rights

ERISA provides that all participants are entitled to:

- Examine, without charge, all documents governing the Health Care FSA, and a copy of the latest annual report (Form 5500), if any, filed by the Health Care FSA with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all documents governing the operations of the Health Care FSA, including the latest annual report (Form 5500) and an updated summary plan description, upon written request; there may be a reasonable charge for copies.
- Receive a summary of the Health Care FSA's annual Form 5500 report, if one is required to be filed, in which case the summary will be provided to each participant as required by law.

In addition to creating certain rights for participants, ERISA imposes duties upon those responsible for the operation of the Health Care FSA. The people who operate your Health Care FSA, called "plan fiduciaries", have a duty to do so prudently and in the interest of you and other Health Care FSA participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit under the Health Care FSA is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your employer review and reconsider your claim. Refer to the section on Operation of the BESTflex Plan for more details about claims denials and appeals.

Enforcing Your ERISA Rights

If your claim for a Health Care FSA 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 Health Care FSA and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $152 per day until you receive the materials, unless the materials were not

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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, you may file suit in a state or federal court.

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

If you have any questions about the Health Care FSA, contact your plan administrator (in most cases, your employer; see *My Company Plan* to confirm this) or Employee Benefits Corporation. If you have any questions about this *Summary Plan Description* or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

If your plan is not subject to ERISA, this statement of ERISA Rights is not applicable.

HIPAA and Privacy

Summary of Privacy Practices

Please refer to the Notice of Privacy Practices provided by your employer for a complete description of privacy practices.

Protected Health Information (PHI) and How We Use It

Whenever a health provider treats you, protected health information (PHI) is created. Health information may be written (medical bills), spoken (physicians discussing x-rays), or electronic (health records stored on a computer).

Our most common use of PHI is for payment of claims. Information received with your reimbursement request includes a receipt or third-party provider statement. The information on the statement is used to verify the date the service was provided, the type of service provided, the name of the provider, and the charges for the service. This information is used only for claims payment purposes.

Protecting your PHI is very important to us. As a participant in the Health Care FSA, you are trusting us with your private information. Be assured that this information will be kept confidential.

Questions or Concerns

Please contact your employer’s privacy officer for more information about HIPAA privacy. You may also contact the Employee Benefits Corporation Director of Compliance at (800) 346-2126.

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Subrogation and Repayment

If you are reimbursed under the Health Care FSA for medical expenses incurred due to illness or injuries caused by the act or omission of a third party, you automatically assign to the Health Care FSA any rights you have to recovery from the third party up to the full amount of the reimbursements. You also will be responsible for repaying out of any recovery any reimbursements paid on your behalf by the Health Care FSA. The details regarding these subrogation rights and your obligation to repay the reimbursements paid on your behalf are set forth in the BESTflex *Plan Document*.

ACCESSING YOUR FUNDS

Paying from Your Health Care FSA with the Benefits Card

Your employer's Health Care FSA includes a Benefits Card. The Benefits Card is a prepaid debit card you can use to pay for eligible expenses with funds directly from your Health Care FSA balance, instead of tying up your cash and waiting for reimbursement.

The Benefits Card debits your Health Care FSA when you use the card at approved service providers and retailers to pay for eligible expenses. The Benefits Card is the most convenient way for you to access your Health Care FSA funds.

You elect the card by enrolling in the Health Care FSA or, in some cases, by completing a special form.

Receiving Your Card

When you first enroll in the Health Care FSA, the Benefits Card is mailed directly to your home. The envelope includes your Benefits Card, information about using your card, and a cardholder agreement.

Your plan year elections are automatically available on your card at the beginning of each new plan year; you will not receive a new card each year as long as you are continuously enrolled in the Health Care FSA. A new Benefits Card will be mailed to you 30 days prior to your card expiration date.

Using Your Card

Your Benefits Card is loaded with your available balance and may be used for any expense eligible for reimbursement from your Health Care FSA. The Benefits Card can be used to pay for an expense if:

- The expense has not been and is not going to be paid by other coverage
- The expense does not exceed your available balance
- You use your Benefits Card at approved service providers and retailers
- You do not use your Benefits Card for ineligible over-the-counter (OTC) medicines

Using the Benefits Card with Other Insurance Coverage

You cannot use your Benefits Card to pay for an expense that is going to be paid by other coverage such as health insurance, dental insurance, vision insurance, or a Health Reimbursement Arrangement (HRA). You can use your Benefits Card to pay for the portion of an expense that isn't covered by other coverage, such as a copay or coinsurance.

Before you pay a doctor's bill or other expense with your Benefits Card, make sure no other plan covers that expense.

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When Your Expense Exceeds Your Available Balance

If your total eligible expense exceeds your Health Care FSA available balance, you can use your Benefits Card to pay for the amount remaining in your account, and pay for the rest of the expense with some other payment method.

To check your available balance, access your account at www.ebcflex.com or contact us.

Where You Can Use Your Benefits Card

When you enroll in a **limited health FSA**, you can use your Benefits Card at dental and vision provider offices. Your card can only be used for dental and vision OTC items purchased at a dental or vision provider's office (a doctor's prescription is necessary for any OTC medication).

Any other purchases from providers that are not dental or vision offices, including eligible expenses from approved retailers and pharmacies, must be submitted as claims for reimbursement from your limited health FSA. Refer to the section on Submitting Claims for Reimbursement for details.

Benefits Card transactions may require that you submit expense documentation to verify your expenses are eligible for payment from your Health Care FSA. Refer to the Benefits Card Transactions and Documentation Requests section for details.

When You Can Use Your Benefits Card

You can only use your Benefits Card in the same plan year the expense is incurred. You cannot use your Benefits Card for prior plan year expenses. To be reimbursed during your runout period for prior plan year expenses, submit those expenses online, through the mobile app, or as paper claims for reimbursement. Refer to the section on Submitting Claims for Reimbursement for details.

Your employer's plan includes a grace period, which extends your plan year by 2 months and 15 days. Refer to the Grace Period section for more details. The grace period extends the cutoff dates for using your Benefits Card, allowing you to use your Benefits Card to pay for eligible expenses you incur from the very beginning of the plan year through the entire grace period. Once your grace period ends, you cannot use the Benefits Card for prior plan year expenses.

During your grace period, you may have expenses eligible for reimbursement from two plan years – the old plan year and the new plan year. Consider how you use your Benefits Card for new plan year expenses during the grace period if you have not yet submitted all of your expenses incurred during the old plan year. Payments and reimbursements are processed in the order they are received, and during the grace period, the Benefits Card applies all of your transactions against the old plan year balance. Submit expenses from the old plan year first before submitting any new plan year expenses to ensure you receive your maximum benefit payout.

Benefits Card Transactions and Documentation Requests

Save your expense documentation whenever you use your Benefits Card to pay for eligible expenses. Your Benefits Card transaction may be able to be automatically verified as an eligible expense under some circumstances; in all other situations, however, you will be required to provide documentation verifying that the transaction was for an eligible expense.

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Automatic Substantiation

Your Benefits Card will attempt to electronically verify that your purchase is eligible for payment from your Health Care FSA at the point of sale. If the Benefits Card transaction cannot be automatically substantiated, but the card is accepted for payment, you will be sent a Documentation Request that requires you to verify that the expense is eligible for reimbursement from your Health Care FSA. See the following section for more information about Documentation Requests.

In some cases, when a Benefits Card transaction cannot be automatically substantiated, your card may be declined. If you believe the purchase is eligible for reimbursement from your Health Care FSA, you can pay for the expense with another payment method and submit a claim for reimbursement. Refer to the Submitting Claims for Reimbursement section for details.

Documentation Requests

If your Benefits Card transaction cannot be automatically substantiated at the point of sale, you will be sent a Documentation Request to verify the expense is eligible for reimbursement from your Health Care FSA. We are required to verify the entire expense is eligible each and every time the card is used. This is a requirement under federal law, and the IRS provides no exceptions to this rule.

We prefer to send Documentation Requests via email to ensure you are notified quickly about the need for additional information. If we are not able to send a Documentation Request via email, we send it to you via US Mail, which may cause a delay in communicating about and processing your expense documentation. You may review any outstanding Documentation Requests and update your notification preferences by logging into your account at www.ebcflex.com. You may also contact us at any time to help you identify outstanding Documentation Requests for your Benefits Card transactions.

Refer to the Submitting Benefits Card Documentation for details on how to respond to a Documentation Request.

Benefits Card Suspensions

Your Benefits Card may be deactivated according to the terms of your cardholder agreement. Typically, deactivation occurs because a card transaction has not been appropriately verified as an expense eligible for reimbursement from your Health Care FSA after multiple Documentation Requests have been sent. You will be notified of the deactivation via US Mail, even if you have chosen email communications for most notifications.

If you cannot submit valid, itemized expense documentation that demonstrates a Benefits Card transaction is eligible for reimbursement from your Health Care FSA, you must repay the plan in the amount of the ineligible expense, or contact us to offset the ineligible expense with a valid claim.

Your Benefits Card will only be reactivated when valid documentation or repayment is submitted to the plan, or your employer otherwise recoups the ineligible amount in accordance with federal regulations.

Submitting Benefits Card Documentation

When you receive a Documentation Request, upload your documentation from your online account at www.ebcflex.com or via our mobile app. Or, you may print the tear-off portion of the Documentation Request, include the required expense documentation, and send it to us via email, fax, or US Mail. Your Benefits Card transaction documentation must include all of the following:

- Date(s) of Service
- Type of expense

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- Amount of the expense incurred
- Name of Service Provider

Note: Cancelled checks, credit card statements or previous balance statements cannot be used as expense documentation.

Please, do not:

- Submit Benefits Card expense documentation attached to a Claim Form.
- Send expense documentation to us when you have not received a Documentation Request.

Losing Eligibility and the Benefits Card

If you become ineligible to participate in the Health Care FSA for any reason, such as a termination of employment or a reduction in hours, your Benefits Card is closed and you can no longer incur expenses for reimbursement from your Health Care FSA. During your runout period, you must submit a claim for reimbursement if you want to use your account to pay for expenses you incurred while you were eligible. Refer to the section on Losing Eligibility Mid-Year for more information.

Submitting Claims for Reimbursement

You can submit claims for reimbursement online (www.ebcflex.com or mobile app) or by completing a claim form and sending it by email, fax, or mail. You can access the Claim Form at www.ebcflex.com > Quick Forms. Include purchase documentation to prove the expense is eligible for reimbursement from your plan.

Your documentation must include all of the following:

- Provider or point-of-sale merchant name
- Services received or items purchased
- Date service was received or purchase was made
- Amount of the expense

Note: The IRS does not recognize previous balance statements, personal checks, or credit card statements as valid proof of an expense.

Plan Year Runout Period

Your plan provides you with a specific number of days after your plan year ends to request reimbursement for eligible expenses you incurred prior to the end of the plan year. This period of time is called the *runout period*.

Refer to *My Company Plan* for details regarding the length of the runout period for your plan.

Runout and the Grace Period

Your Health Care FSA plan includes a grace period, which extends your plan year by 2 months and 15 days. The grace period allows you to submit claims for eligible expenses you incur from the very beginning of the plan year through the entire grace period. The grace period often will overlap significantly with your runout period.

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When you incur an expense during your 2 ½ month grace period and submit a claim for reimbursement for the expense during your runout period, the claim is first processed from your old plan year balance and you are reimbursed from those funds. Once that balance is fully exhausted, remaining claim amounts are reimbursed using funds from the new plan year (as long you enrolled in the new year and have funds available).

Claims are processed in the order they are received, so you may want to wait until you have been reimbursed for all expenses incurred during the old plan year before submitting claims for any expenses you incur in the new plan year during the 2 ½ month grace period.

Your claims cannot be reprocessed or reordered to process expenses from a specific plan year. It is your responsibility to manage your funds for each plan year and submit claims for reimbursement accordingly.

Direct Deposit

When you use Direct Deposit we deposit your reimbursements directly into your financial institution checking or savings account. Set up Direct Deposit during your enrollment process or fill out the Direct Deposit Authorization form at www.ebcflex.com > Quick Forms.

If you are signed up for Direct Deposit and submit an eligible claim, we'll send you an email notification when funds are deposited in your account.

Use It or Lose It Rule

IRS regulations prohibit your employer from returning any unspent FSA funds to you, or transferring them to a different account. Funds remaining at the end of the plan year's runout period are forfeited and returned to your employer.This includes any funds not spent during your grace period. Your employer uses these funds to offset any losses experienced by the employer under the plan, or to defray administrative costs associated with offering these benefits.

Thoughtful planning can minimize having to return funds to the plan for ineligible expenses or forfeiting unspent funds at the end of the plan year.

Losing Eligibility Mid-Year

If you become ineligible to participate in an FSA for any reason, such as a termination of employment or a reduction in hours, contributions to your plan stop.

After the loss of eligibility, you can no longer incur expenses for reimbursement from your Health Care FSA, unless you are eligible for and elect Health Care FSA continuation coverage under COBRA, as explained in the section regarding Your Rights Under the Health Care FSA. You may have additional time after your loss of eligibility date during which you may submit previously incurred claims. Refer to *My Company Plan* for more information. Please contact Employee Benefits Corporation if you require more detail regarding claims submission after you lose eligibility. You can continue to submit claims for reimbursement from your Dependent Care FSA for service dates through the end of the plan year in which you lost eligibility as long as you submit the claim by the end of the plan's standard runout period as identified in *My Company Plan*.

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PERMITTED ELECTION CHANGE EVENTS

An election to participate in the plan must be made prior to the start of the plan year. You can only change your group premium election or FSA election amounts during the plan year if you experience a certain event for which the IRS and the plan permit election changes. Health Savings Account (HSA) contributions made through the BESTflex Plan may be changed at any time during the plan year, as long as the election change is prospective (that is, after the request for the change is received), and is consistent with the procedures defined by your employer. This means that unlike other BESTflex Plan benefits, you can stop, start, increase, or decrease your HSA contributions for any reason.

You may also be able to make changes if you take a family, medical, or military leave of absence. Refer to the Leaves of Absence section for more information.

Notify Your Employer of Changes

If one of the permitted election change events applies to you, inform your employer as soon as possible but no later than 30 days after the event. For Medicaid/State Children's Health Insurance Plan (CHIP) events, you are allowed 60 days to make the change. You may be required to submit a Permitted Election Change Form. If you don't notify your employer within these timeframes, you may not change your election.

Changes are generally effective as of the signature date on the submitted documentation for the change or the event date, whichever is later (see HIPAA Special Enrollment Event below for exceptions). Changes to premium payments may not take effect until a corresponding coverage change is made.

Types of Permitted Election Change Events

A. **Change In Status Events**: Various events that cause you, your spouse, or your dependent to gain or lose coverage under the BESTflex Plan or a plan of your spouse's employer, and allow you to make an election change that corresponds with that gain or loss of coverage.

   There are two steps used to determine whether you can make a change due to one of the following events. **First**, the change of status must occur. **Second**, there must be a gain or loss of eligibility under the plan due to the event.

   a. **Marital status**: Legal changes including marriage, death of a spouse, divorce, legal separation or annulment

   b. **Number of dependents**: Events that change the number of your dependent(s) for tax purposes, including birth, death or adoption

   c. **Employment status**: Changes such as termination or commencement of employment, a change in the number of hours worked, a strike or lockout, a switch between part-time and full-time or vice versa, a work site change, or the beginning or end of an unpaid leave of absence by you, your spouse, or your dependent(s)

      i. Employees terminated and rehired within 30 days are reinstated at their prior annual elections

      ii. Employees terminated and rehired after 30 days are not allowed to participate in the FSA until the next plan year

      iii. Employees beginning or ending an unpaid leave may only change elections if the leave causes a gain or loss of eligibility for the plan

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d. **Dependent eligibility**: Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or similar circumstances

e. **Residence**: a change in the residence of you, your spouse, or your dependent that results in a gain or loss of eligibility under a group insurance plan (not the Health Care FSA or Dependent Care FSA)

B. **HIPAA Special Enrollment Event**: Allows you to make a change that corresponds with special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to individuals who lose other health insurance coverage or become the spouse or dependent of an employee through marriage, birth or adoption; or to a dependent who loses coverage under a state Children's Health Insurance Program (CHIP). Unlike other events, addition of a dependent through birth or adoption may be made retroactive to the event. You may not be able to rely on this event to make changes to any plan other than your major medical plan because HIPAA's portability provisions don't extend to all group health plans.

C. **COBRA Events:** If you, your spouse or dependent becomes covered by your employer's coverage through COBRA or similar state continuation law, you may increase your premium contribution to pay for the coverage. This event does not apply to the Dependent Care FSA or other non-health benefits.

D. **Court Order Event**: Allows you to make a change in accordance with a court order regarding health coverage of your child. You must be able to show that other coverage exists before you can drop coverage. This event does not apply to the Dependent Care FSA or other non-health benefits.

E. **Entitlement to Medicare or Medicaid Event:** Allows you to make a change if you, your spouse, or your dependent enrolls in or loses Medicare or Medicaid coverage. Enrollment in such coverage allows you, your spouse, or your dependent to decrease or cancel the health coverage under your plan. Losing Medicare or Medicaid coverage allows you, your spouse, or your dependent to increase or enroll in health coverage under the plan. This event only applies to group health benefits and not to the Dependent Care FSA or other non-health benefits.

F. **Cost Change Events:** Various events allow you to make an election change that corresponds to a change in the cost of your coverage. These events do not allow you to make changes to your Health Care FSA election.

a. **Automatic Change in Cost:** Your Employer may automatically adjust your insurance premium payments as a result of a cost change that arises from an increase or decrease in the cost of the underlying coverage.

b. **Significant Change in Cost:** Allows you to increase or decrease your election when the cost of coverage significantly increases or decreases under your Employer's plan, including if your cost decreases because you become eligible for premium assistance under a state Children's Health Insurance Program (CHIP). This event allows you to add coverage, or drop coverage and add alternative coverage (or just drop if no alternative coverage is available). If a dependent care provider increases or decreases the cost of care, it is a cost change that allows you to make a corresponding change to your Dependent Care FSA election so long as the dependent care provider is not a relative. Additionally, the availability of a new dependent care provider is a coverage change that

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will allow you to make a corresponding change to your Dependent Care FSA election. This event does not apply to the Health Care FSA.

G. **Coverage Change Events**: Various events allow you to make an election change that corresponds to a change in your coverage. The availability of a new dependent care provider is a coverage change that will allow you to make a corresponding change to your Dependent Care FSA election. These events do not allow you to make changes to your Health Care FSA election.

   a. **Addition of or Significant Improvement to a Benefit Option:** Allows you to add or revoke your election with respect to a new benefit package option (or a significant benefit improvement) offered by your employer. Participants may make a change with respect to only that benefit.

   b. **Elimination or Significant Curtailment of a Benefit Option:** Allows you to make certain changes to your premium election if coverage under your Employer's plan is reduced overall. If the curtailment results in a loss of coverage, you may revoke your election and either drop coverage altogether, or select alternative coverage offered by your employer. If the curtailment does not result in a loss of coverage, you may only revoke your election if you select alternative coverage; you may not simply drop the coverage.

   c. **Change in Coverage Under Another Employer's Plan Event:** Allows you to make or revoke your election if your spouse or dependent's employer's plan increases coverage, decreases coverage, adds a benefit, or makes new enrollment in its coverage available. Changes must correspond to coverage changes under the other employer's plan – for example, this would allow you to revoke your election mid-year if your spouse's plan offers open enrollment and you actually enroll in your spouse's plan.

   d. **Loss of Other Coverage Under A Governmental or Educational Institution Plan:** If you, your spouse, or dependent lose coverage under any governmental or educational institution health plan, you may make an election to add coverage under your employer's plan. Some of the governmental plans affected by this rule are: a state Children's Health Insurance Program, an Indian Tribal government health program, a state health benefits risk pool, or a foreign government group health plan. This event does not apply to the Dependent Care or other non-health benefits

H. **Enrollment in a Another Plan Due to Reduction in Hours:** If you had been reasonably expected to average at least 30 hours of service per week, and your hours have been reduced so that you now are expected to average fewer than 30 hours per week, you may revoke your group health benefit election if the revocation corresponds to your enrollment (no later than the first day of the second month following the month in which you revoked your election) in another plan that provides minimum essential coverage. This event does not apply to the Dependent Care or other non-health benefits

I. **Enrollment in a Marketplace Health Insurance Plan:** If you become eligible mid-year to enroll in a Marketplace Health Insurance Plan (commonly called "Exchange coverage") during an Exchange special or open enrollment period, you may revoke your election and drop your coverage if you enroll or intend to enroll in Exchange coverage. The Exchange coverage must be effective no later than the first day following the date your employer's coverage ends. This event does not apply to the Dependent Care or other non-health benefits

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How Election Changes Affect FSA Reimbursements

Although you may change your FSA election if you experience an event described above, you are not able to reduce any FSA election to an amount that is lower than the amount of contributions you have made or reimbursements you have already received at that point in the plan year. The plan will reimburse you for claims submitted after the change only up to the newly reduced election amount, regardless of when the expense was incurred. Your salary reductions will be decreased to reflect your newly decreased election, taking into account your contributions prior to the change.

If you are permitted to revoke your election, your access to the account will end in the same way as if you had lost eligibility for the plan mid-year. Lowering your election to equal the amount of contributions you've made to the plan at that point in the year effectively revokes your participation in that account. Refer to the section on Losing Eligibility Mid-Year for more information.

If you increase your election as a result of a permitted election change event, the plan will reimburse you for claims submitted after the change only up to the election amount that was in effect on the date the expense was incurred. The amount available to you for reimbursement of claims takes into account all expenses that are reimbursed during the entire plan year. Your salary reductions will be increased to reflect your newly increased election, taking into account your contributions prior to the change.

Your new elections will stay in effect for the remainder of the plan year, unless you experience another permitted election change event later in the same plan year.

LEAVES OF ABSENCE

Your employer may offer paid or unpaid leave programs, including leaves of absence governed by state or federal law. If you take a paid leave and do not lose eligibility for your plan benefits, your payroll reduction amounts will continue throughout the paid leave. For any unpaid personal leave (that is, a leave of absence not mandated by state or federal law), your employer's policies will apply with respect to the affect taking leave will have on your BESTflex Plan benefits. Often, such a leave constitutes a change in employment status which, if it affects benefit eligibility, would be a permitted election change event as described in the previous section.

Family and Medical Leave Act (FMLA) Leave

If your employer is covered by the Family and Medical Leave Act, your coverage under any group health plan must be maintained by your employer while you are on leave in the same manner coverage is maintained for an active employee. This includes your Health Care FSA. However, FMLA leave is a special permitted election change event that allows you to revoke your coverage during the leave, either permanently or just for the duration of the leave.

If you choose to keep your coverage while on FMLA leave and any part of the leave is paid, you will continue to have your regular payroll reduction amounts taken from your paycheck as long as you receive one. If the leave is unpaid, you may continue to make your Health Care FSA contributions or premium payments in one of the following ways:

- By sending monthly payments to your employer by the regular due date. Because you would not receive a paycheck during this time, those payments cannot be pre-tax.

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- By making arrangements with your employer prior to the leave beginning to pre-pay all or some of what is expected to be due for the duration of your leave on a pre-tax basis from your pre-leave compensation. You will only be able to pre-pay portions of the leave that fall within the same plan year as the pre-tax deduction.
- By making any other arrangement with your employer that you both agree upon, such as agreeing to have your payments withheld upon your return from leave.

If you don't pay your Health Care FSA contributions or premium payments while on leave, your employer can terminate your coverage. If your coverage ends for any reason while on FMLA leave, your employer must allow you to resume coverage when you return from leave. Your employer may seek recovery of any unpaid amounts or amounts it paid on your behalf if you don't return to work at the end of your leave, subject to certain exceptions.

Uniformed Services Employment and Reemployment Rights Act (USERRA) Leave

If you leave work for military duty in the Uniformed Services, you have certain rights under this plan. Generally, you are allowed to revoke or continue participation in the plan (assuming you make your share of the contributions). Also, you have the right to be reinstated in the plan when you return from your service. If you go on military duty, please contact your Employer for more information regarding your rights under USERRA.

Please contact your employer if you have other questions about leaves of absence and your benefits.

OPERATION OF THE BESTFLEX PLAN

The BESTflex Plan Administrator is your employer or another entity designated by your employer. The Plan Administrator has full and complete authority, responsibility, discretion, and control over the management, administration, and operation of the BESTflex plan. This includes, but is not limited to:

- Formulating, adopting, issuing, and applying procedures, rules and changes
- Altering or amending such procedures and rules in accordance with the law
- Construing and applying the provisions of the plan
- Making appropriate determinations concerning eligibility for benefits

The Plan Administrator's determinations shall be final, conclusive and binding on all parties, unless otherwise determined by legal process.

Funding

The plan is funded by the general assets of your employer in accordance with the payroll reduction elections you have made under this plan. Your employer may also contribute to the plan. Please refer to *My Company Plan* for details specific to your BESTflex Plan.

Notice of Denials and Appeals

Please review *My Company Plan* to verify the number of days available for you to submit claims under your company's BESTflex Plan. All claims and required documentation must be submitted within this period. All claims under a Health Care FSA are considered post-service claims, and initial claims will be decided no later than 30 days from receipt of the claim after the end of the plan year or your termination from employment.

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If, for reasons beyond the control of Employee Benefits Corporation, the claim cannot be decided within this 30-day period, Employee Benefits Corporation has an additional 15 days to review the claim, as long as you are notified of the delay within the original 30-day window.

If your claim is denied, you will receive a written notice citing the specific reasons for the denial and the plan provisions on which it is based. You will also be provided with a description of any additional documents or material you might need to complete an incomplete claim and an explanation of why it is necessary. The notice of claim denial will also provide you with an opportunity to receive information about the specific rule, guideline, or other similar criteria that was relied upon in the denial.

Failure to properly substantiate a claim or follow reimbursement procedures for the plan, or requesting reimbursement for an ineligible expense may result in claim denial or offset against future reimbursements.

If your claim has been denied for any reason, you have 180 days to submit a written appeal to Employee Benefits Corporation, detailing why you feel your claim should have been paid. You may also provide any additional documentation you feel is relevant. Your appeal will be decided by someone other than the individual or any subordinate of the individual who made the initial determination of your claim. Employee Benefits Corporation may consult with your employer or another named plan fiduciary in making a determination on appeal.

Employee Benefits Corporation provides you with notice of any information and documents that may be relevant to the appeal of your claim. Your appeal is decided no later than 60 days from the receipt of the appeal.

If your appeal is denied, you will receive a written notification of the *adverse benefit determination on review* with the reason(s) for the denial and the plan provisions on which it is based.

If the appeal denial is based on any internal rule, guideline, protocol or other criterion, it will be provided to you, free of charge, upon your request. You may obtain from Employee Benefits Corporation any relevant information regarding your claim. You will also be informed that you and your Plan may have other voluntary alternative dispute resolution options, such as mediation, and information about contacting your local U.S. Department of Labor Office and your State insurance regulatory agency, and that you may have the right to sue in federal court under ERISA (Employee Retirement Income Security Act of 1974) if your employer is subject to ERISA.

Any determination on appeal is binding on all parties. You must exhaust all administrative remedies before you may file a claim or lawsuit in court. The claims and appeals process will be applied in a manner that complies with all applicable laws and regulations.

Termination and More Information

Assignment of Benefits

You cannot assign your plan benefits to anyone else. The plan will not reimburse anyone other than you or your estate for covered expenses.

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Subrogation and Repayment

The BESTflex Plan may recover overpaid benefits and erroneously paid benefits, including reimbursements or payments to you that are later paid for or reimbursed by another plan or a third party. Refer to the section on Your Rights Under the Health Care FSA for information on subrogation and repayment under the Health Care FSA.

Keep Your Employer Informed of Changes

In order to protect you and your family's rights, you should keep your employer or Plan Administrator informed of any changes to your marital status or a child's status as a dependent under the group health plan's policy. It is important for our records to reflect your current email address, mailing address, phone number, and name. If any of these change mid-year, please notify your employer, who will then contact us. Certain updates may be submitted online directly from your account at www.ebcflex.com.

Termination of the BESTflex Plan

Your employer reserves the right to modify or terminate the BESTflex Plan at any time. You will be advised of any such change.

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