

SUMMARY PLAN DESCRIPTION

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

Your Employer has adopted a Flexible Spending Account Plan (also referred to as “the Plan” or “this Plan”) to provide compensation alternatives for eligible employees and their dependents. By participating in the Plan you are able to “give up” a part of your taxable compensation and choose certain “tax free” benefits instead. If you would normally pay for these benefits with “after-tax” dollars, the Plan enables you to now pay with “pre-tax” dollars and will save you money. The Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125(b) of the Internal Revenue Code.

Here’s an example of how the Plan works: If you normally pay for a portion of your group health insurance with after-tax dollars, you may elect to have that amount withheld from your wages and salary in accordance with the terms of the Plan. The amount withheld under the Plan is withheld on a pre-tax basis, and is then used to pay your portion of the health insurance premium. Since you are paying your portion of the premium with pre-tax dollars, you pay less tax and save money.

Depending on the benefit programs your employer has elected to offer under the Plan, you may be able to pay for various insurance premiums, receive reimbursements for medical or dependent care expenses, or make contributions to a health savings account, in this pre-tax manner.

This Summary Plan Description summarizes in plain language the operation of the Flexible Spending Account Plan. If you have questions about the information contained here or about the legal documents, contact your legal or tax consultant. All issues concerning the operation of the Plan will be resolved in accordance with the Plan documents and the law. In the event of any inconsistency between this Summary and the Plan, the terms of the Plan document will govern.

WARNING: Participation in the Plan may not benefit everyone. You must understand the operation of the Plan, your elections and their consequences before deciding to participate. Remember, participation can cost you money if you make improper elections or do not follow the rules of the Plan or the governing laws.

PARTICIPATION, RENEWAL AND TERMINATION

WHO IS ELIGIBLE TO PARTICIPATE?

If you are an employee and have met the required eligibility standards and waiting period set forth in the PLAN INFORMATION SHEET, you are eligible to participate. To become a participant you must complete and sign an enrollment form and salary reduction agreement prior to your entry date. Your “entry date” is the date on which you become eligible to participate in the Plan as indicated below:

- a. If you are an eligible employee on the date the Plan goes into effect, your entry date will be the effective date of the Plan; or

- b. If you become an eligible employee after the effective date of the Plan, your entry date will be the first day of the month following or coinciding with the date you become an eligible employee.

You may have different waiting periods or different eligibility requirements (and thus different entry dates) for different benefit programs offered under the Plan. The PLAN INFORMATION SHEET will also indicate whether employees or classes of employees are prohibited from participating in the Plan or one or more of its benefit programs.

If you do not complete the required paperwork prior to your entry date indicated above, you will not be eligible to enroll in the plan until the next Plan year's open enrollment period.

You will be given notice of your eligibility to participate prior to your entry date so that you have time to decide whether or not to participate and to make your elections.

RENEWALS

After the initial period of coverage, you may renew your participation for the next Plan year by filing your elections with your Employer or the designated representative during the next open enrollment period. Except as provided on the PLAN INFORMATION SHEET, failure to make new elections during open enrollment will be treated as an election not to participate in the Plan during the following Plan year. However, if the PLAN INFORMATION SHEET contains a paragraph titled "Deemed Elections," then for the Programs designated in that paragraph and as further explained there, unless you expressly change your election for those Programs during the open enrollment period, you will be deemed to have elected for the upcoming Plan year to continue the elections in effect for those Programs for the current Plan year, even if you do not turn in an election form. Accordingly, you should consult the PLAN INFORMATION SHEET to see if any deemed elections apply to any Program, and if they do, and if you want to stop participating in a Program to which deemed elections apply, you should make sure to change your election by turning in a properly completed election form during the open enrollment period.

WHEN DOES PARTICIPATION END?

You will cease to be a Participant in the Plan as of the earliest of:

- a. The first day of a Plan Year for which you decline to participate in any benefit program provided under the Plan;
- b. If you terminate employment or otherwise cease to satisfy the eligibility requirements, the date as of which you cease to have a right to any benefit under the Plan; or
- c. The date on which the Plan is terminated.

The date your participation will cease under the different benefit programs offered under the Plan varies from program to program. Under the various Insurance Premium

Programs described below, your participation in each program will, unless otherwise expressly stated, cease on the date you terminate employment or otherwise cease to be eligible under the Plan; provided that you will continue to be covered under any insurance contract through the end of any period for which premiums have already been paid as of the date you terminate employment or otherwise cease to be an eligible employee. For example, if you terminate employment on May 15, but your group health insurance premium has previously been paid through May 31, you will continue to be covered under the group health insurance plan through May 31. Nothing in this Section is to be interpreted, in any way, as diminishing or affecting any rights you may have to continue coverage under COBRA or other applicable law. The date your participation ends under the other benefit programs are described in the sections below relating to those benefit programs.

FRAUDULENT USE

WARNING: If the Plan Administrator determines that you have made fraudulent use of the Plan, your participation in the Plan will terminate and you will forfeit your unused funds.

BENEFITS

WHAT ARE YOUR BENEFITS?

As specified on the PLAN INFORMATION SHEET, you may elect to reduce your salary or wages as of your entry date in the Plan to participate in one or more of the following benefit programs:

- a. Group Health Insurance Premium Program
- b. Uninsured Health Expense Reimbursement Program
- c. Dependent Care Assistance Program
- d. Group Term Life Insurance Premium Program
- e. Disability Insurance Premium Program
- f. Other Health Insurance Premium Program
- g. Other Non-Health Insurance Premium Program
- h. Health Savings Account Program

The benefit programs are explained more fully below (but remember, the PLAN INFORMATION SHEET shows the benefit programs actually available under the Plan). The benefit programs described in a., d. e., f. and g. are sometimes referred to in this summary as the "Insurance Premium Programs."

GROUP HEALTH INSURANCE PREMIUM PROGRAM

This benefit program provides payment by the Plan of your portion of any group health insurance premiums, provided you elect this coverage on the applicable Annual Enrollment Form. This benefit is generally funded through pre-tax dollars you elect to have withheld from your salary or wages. In some situations your Employer may fund a portion of the premium.

Eligible group insurance premiums include the premiums paid for medical and hospitalization insurance, major medical insurance, dental insurance, and/or vision insurance made available by the Employer. The insurance may cover you, your spouse, and/or any eligible dependent children. You may not claim reimbursement if you can be reimbursed for the premium cost by any other source.

UNINSURED HEALTH EXPENSE REIMBURSEMENT PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may use the program to pay for eligible medical expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary. The maximum salary reduction you can elect under this program is defined in the PLAN INFORMATION SHEET.

If you elect this program, the Employer will establish an Uninsured Health Expense Reimbursement Account in your name. The money that you elect to have reduced from your salary or wages will be credited to this account. Your account will also be credited with Employer non-elective contributions, if any, made on your behalf, as indicated in the PLAN INFORMATION SHEET. The Plan will then use the total amount credited to your account to reimburse you for your and your spouse or dependents' eligible medical expenses.

Eligible medical expenses are generally defined in Section 213(d) of the Internal Revenue Code and a partial list of eligible medical expenses has been made available to you. The Uninsured Health Expense Reimbursement Program cannot reimburse you for any expenses that have been reimbursed by any other plan or source, for any insurance premiums, for cosmetic surgery, or for any other medical expenses not eligible to be provided through a cafeteria plan. In addition, you cannot claim a tax deduction for any expenses reimbursed under this program.

Your claim for medical expenses reimbursement must include the following:

- a. A statement from the provider of your medical services that you have incurred the expense and the amount of your expense; and
- b. A signed Reimbursement Request Form
- c. A statement from the provider that the expense is medically necessary may be required in some instances.

Subject to this program's maximum allowable election you will be entitled to receive medical expense reimbursement for the full amount of your election (plus any Employer non-elective contributions credited to your account, but minus prior reimbursements during the Plan Year) at all times during the elected period of coverage. This is known as the "uniform coverage" rule.

If the Employer also maintains a health reimbursement arrangement plan (HRA), your salary reductions will not be used directly or indirectly to fund reimbursements from the HRA--only Employer contributions will be used for that purpose. If medical expenses are otherwise reimbursable under both the HRA and the Uninsured Health Expense Reimbursement Program, the expenses will first be reimbursed under the Uninsured Health Expense Reimbursement Program until your Uninsured Health Expense

Reimbursement Account has been exhausted, and only then will expenses be reimbursable from the HRA, unless the PLAN INFORMATION SHEET provides otherwise.

You should be aware that the Uninsured Health Expense Reimbursement Program is subject to the “use it or lose it” rule discussed further below. You should read that section before electing to participate in the program.

Your participation under the Uninsured Medical Expense Reimbursement Program will end as indicated on the PLAN INFORMATION SHEET. Thus, if indicated in the PLAN INFORMATION SHEET, participation in the program may require an election of coverage for an entire Plan Year. This means that even if you terminate employment during the course of the year, you must continue making regular contributions to the Plan, in accordance with your election for the Plan Year. If you wish, you may elect to have the balance of your contributions for the Plan Year withheld from your final compensation check. In this way, the remaining payments may be deducted on a pre-tax basis, which preserves the tax advantages of participation in the Plan. Remember, to the extent you do not elect to have your employer withhold the balance of your contributions from your last paycheck, you will be obligated to continue regular payments to the Plan, in accordance with your initial election. In the alternative (again as designated in the PLAN INFORMATION SHEET), your participation in the Uninsured Health Expense Reimbursement Program may end as of the date you terminate employment or otherwise cease to be eligible to participate in the program (subject to your right, if any, to continue coverage under COBRA). In that event, you may not receive reimbursements for expenses incurred after the date you terminate employment or otherwise cease to be eligible, but you will have a run-out period of 90 days in which to file reimbursement claims for expenses incurred prior to such date. Any amounts left in your account after that run-out period will be forfeited.

DEPENDENT CARE ASSISTANCE PROGRAM

If you elect this program, your salary or wage reductions are used to reimburse you for expenses you incur for the care of an eligible dependent (defined in Section 152, as modified by Section 21 of the Internal Revenue Code). You may receive reimbursements under this program only if the dependent care is necessary to enable you and your spouse to work or seek employment, or if you work and your spouse is a student or is disabled. The dependent must reside with you more than half the year for the expenses with respect to that dependent to be eligible for reimbursement under this portion of the Plan.

The maximum salary or wage reduction allowed by the Plan is an amount equal to you and/or your spouse’s earned income (as defined by the IRS). Also, your election cannot exceed \$5,000. In the case of a married individual filing a separate income tax return, the election cannot exceed \$2,500 (Code Section 129).

Using the Plan for reimbursement of dependent care expenses results in a reduction of your taxable salary. Therefore, your tax payments are reduced. Depending on your income tax bracket, you may also be entitled to claim the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these

(or a combination of the two), but you may not take a tax deduction of those expenses reimbursed under this Plan, or vice versa. **You must file a 2441 Child Care Tax Credit form with your annual tax filing.**

Reimbursement of dependent care expenses will be made from your Dependent Care Spending Account. Your reimbursement will not exceed the balance in your Dependent Care Spending Account at the time that your reimbursement claim is received or paid.

The amount you elect to withhold from your salary will be reported to your employer. Your employer is required to report this amount on your IRS W-2 form.

You should be aware that the Dependent Care Assistance Program is subject to the "use it or lose it" rule discussed further below. You should read that section before electing to participate in the program.

If you have elected to participate in the Dependent Care Assistance Program for a Plan Year and you leave employment or otherwise cease to be eligible during the middle of the Plan Year, you will not be allowed to contribute to your Dependent Care Spending Account after that date. However, you will be eligible for reimbursements from your Dependent Care Spending Account for the remainder of that Plan Year, even if the expenses were incurred after your termination of employment or loss of eligibility, as long as you have a positive balance in your account.

GROUP TERM LIFE INSURANCE PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may elect to use pre-tax salary or wage reduction to pay premiums for up to \$50,000 worth of group term life insurance. You should review the PLAN INFORMATION SHEET to determine whether this benefit is available.

DISABILITY INSURANCE PREMIUM PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may elect to use pre-tax salary or wage reduction to pay disability premiums offered by the Employer. You should review the PLAN INFORMATION SHEET to determine whether this benefit is available. Your participation in the Disability Insurance Premium Program has tax consequences you should consider. If you pay for disability premiums with pre-tax dollars under this Program, your tax burden this year will be reduced (because you will not pay taxes on the money used to pay the premium), but you will be taxed on any disability insurance proceeds you receive should you become disabled. On the other hand, if you pay for disability premiums with after-tax dollars outside the Program, your tax burden this year will be increased (because you will pay taxes on the money used to pay the premium), but you will receive any insurance proceeds tax-free should you become disabled. You should keep this in mind when deciding whether to pay for disability benefits inside or outside the Plan.

OTHER HEALTH INSURANCE PREMIUM PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may also be able to elect other forms of health insurance made available through the Plan, and pay for the applicable premiums on a pre-tax basis, in the same manner as described above with respect to the Group Health Insurance Program. Examples of types of “other” insurance might include special cancer insurance, additional hospital insurance, etc. To verify the availability of this benefit, check the PLAN INFORMATION SHEET.

OTHER NON-HEALTH INSURANCE PREMIUM PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may also be able to elect other forms of insurance not constituting health insurance and pay for the applicable premium on a pre-tax basis, in the same manner as described above with respect to the Group Health Insurance Program. To verify the availability of this benefit, check the PLAN INFORMATION SHEET

HEALTH SAVINGS ACCOUNT PROGRAM

If this benefit program is elected by the Employer for inclusion in the Plan, you may elect to reduce your salary or wages and have that amount contributed to a health savings account (HSA) set up on your behalf. You may then control the investment of funds in your HSA and receive reimbursements for medical expenses allowed by law without sending reimbursement requests to the Employer or other administrator involved with the Plan. In addition, amounts in your HSA are non-forfeitable and not subject to the “use it or lose it” rule discussed below. You should review the PLAN INFORMATION SHEET to determine whether the HSA Program is available.

The maximum contribution that you may make through the Plan to your HSA is designated on the PLAN INFORMATION SHEET, but such maximum is subject to other limits prescribed by law, including but not limited to Employer non-elective contributions, if any, made to the HSA on your behalf.

Your participation in the HSA Program will end on the day on which you terminate employment or cease to be an eligible Employee under the rules generally applicable to the Plan. In addition, you are only eligible to participate in the HSA Program during a month if you are an “eligible individual” (as that term is defined in Section 223(c)(1) of the Internal Revenue Code) on the first day of that month. Generally, you are an “eligible individual” for these purposes only if you are covered by a high deductible health plan on the first day of the month, and you are not covered by any health plan that is not a high deductible health plan on that day unless the non-high deductible health plan provides only permitted coverage or preventive care. A high deductible health plan is a health plan with deductibles satisfying certain limits defined by law (in 2004, deductibles must be at least \$1,000 but not more than \$5,000 for self-only coverage, and at least \$2,000 but not more than \$10,000 for family coverage; those figures are indexed for inflation). “Permitted coverage” means coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, or insurance for a specific disease or paying a fixed amount per day or other period for hospitalization. “Preventive care” generally means amounts defined as

such under Section 223 of the Internal Revenue Code, and includes periodic health evaluations, routine prenatal and well-child care, child and adult immunizations, obesity weight-loss programs, and various screening services. You should see the Employer for more information about preventive care.

Plans such as the Uninsured Health Expense Reimbursement Program can count as a non-high deductible health plan. Accordingly, unless that Program reimburses you only for expenses that qualify as permitted coverage or preventive care, you cannot elect to participate in both the HSA Program and the Uninsured Health Expense Reimbursement Program. Similarly, if the health plan underlying the Group Health Insurance Program is not a high deductible health plan, you cannot elect coverage under that plan and the HSA Program. Your Employer will provide you upon request with more information about what benefit programs you may elect if you also want to elect the HSA Program.

If you have further questions about the HSA Program or how HSA's work, please contact your Employer.

HOW THE PLAN OPERATES

GENERAL RULES

You must make all elections about the use of the Plan before your entry date into the Plan.

Only expenses incurred on or after your entry date and prior to the end of the Plan year are eligible for payment. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid.

The amount reduced from your salary or wages cannot exceed the amount of your annual salary or wages.

You may submit claims incurred during your “period of coverage” for ninety (90) days after the period of coverage. Claims submitted beyond this “run out” period are ineligible for reimbursement. Your period of coverage is generally a Plan Year, but if you begin or end participation in the middle of the Plan Year, the period of coverage is the portion of the Plan Year during which you were a participant in the Plan.

You and individuals who qualify as your dependents may receive benefits under the Plan. An individual may qualify as your dependent for purposes of this Plan even if that individual is not your tax dependent. An individual who would qualify as your tax dependent but has gross income in excess of the exemption amount, is a dependent of a dependent, or is married and files a joint tax return with his or her spouse, will be considered your dependent for purposes of this Plan. For purposes of the Dependent Care Assistance Program, a dependent must reside with you for more than half of the year for expenses with respect to that dependent to be eligible for reimbursement under that portion of the Plan.

ELECTION CHANGES

As a general rule, your elections for the Plan Year are irrevocable for the balance of the year. Certain exceptions apply, as described below:

For the Insurance Premium Programs (such as the Group Health Insurance Premium Program) and the Dependent Care Assistance Program, you may be eligible to revoke your election and make a new election for the balance of the Plan Year upon:

- a. A Change in Status. The Plan allows you to make a mid-Plan year change or revocation of a benefit election if the change or revocation is consistent with a change in status. In this regard, a change in status is any of the following:
 - An event that changes the Participant’s legal marital status, including marriage, death of a Spouse, legal separation, or annulment;
 - An event that changes the number of the Participant’s Dependents, including by reason of birth, adoption, placement for adoption, or death of a Dependent;

- Any of the following events that change the employment status of the Participant or the Participant's Spouse or Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in work site; and any change in employment status that causes the Participant, Participant's Spouse or Participant's Dependent to become (or cease to be) eligible under this Plan, any employee benefit plan underlying this Plan, or any cafeteria plan or employee benefit plan of the Employer of the Participant's Spouse or Participant's Dependent (e.g., a change from hourly to salaried status where such change affects eligibility);
- An event which causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the applicable plan;
- A change in the place of residence of the Participant or the Participant's Spouse or Dependent.

Generally, a revocation or change of your election is consistent with a change in status only if it is on account of and corresponds to a change in status that affects eligibility under an employer's plan. For example, if your spouse terminates employment and loses healthcare coverage under the former employer's plan as a result, then that is a change in status affecting eligibility for health coverage; if you then add your spouse under the Employer's health plan, you could modify your election under the Group Health Insurance Premium Program to pay for the increase in premiums under this Plan. An election change under the Dependent Care Assistance Program is consistent with a change in status if the election change is on account of and corresponds with a change in status that affects dependent care expenses.

- b. Significant Change in Cost or Coverage. If the cost of a plan underlying the Insurance Premium Programs increases (or decreases) during a Plan year, then your elections will generally be automatically adjusted to reflect the increase (or decrease) in cost. The Plan allows the Employer, in the Employer's discretion, to offer you and other affected participants new elections under certain limited circumstances due to a significant change in the cost or coverage of a plan underlying the Insurance Premium Programs. The Employer will notify you if and when such election changes become available. Under the Dependent Care Assistance Plan, however, the following rules apply: (a) if the cost charged to you by your dependent care provider significantly increase or decreases during a Plan year, then you may make a corresponding change in your dependent care election unless the cost of coverage is imposed by a dependent care provider who is a relative of yours; and (b) if you have an increased or decreased need for dependent care, or a change in dependent care providers, then you may make a corresponding change in your dependent care election. Thus, for example, if your child starts

school, or moves to another daycare, you may change or revoke your dependent care election.

- c. Changes Pursuant to Your HIPAA Enrollment Rights. The Plan allows you to make election changes pursuant to your enrollment rights under HIPAA, which are set forth in Section 9801(f) of the Internal Revenue Code. In brief, those rights provide that if you lose other health plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, you may be able to change your health plan elections and make a corresponding change to your elections under this Plan. If you would like to do so, you should contact the Employer as soon as possible after the event occurs, but in no case later than 30 days after that event.
2. For the Uninsured Health Expense Reimbursement Program, the only time you may change your election is prior to the beginning of each Plan Year, or if specified in your PLAN INFORMATION SHEET, after a change in status as defined above. You are not allowed to change your elections under the Uninsured Health Expense Reimbursement Program under HIPAA or as a result of a significant change in cost or coverage. Thus, for example, if in the middle of a Plan year your health insurance deductible rises from \$250 to \$500, you may not make an election change under the Uninsured Health Expense Reimbursement Program as a result of that increased deductible.
3. For the HSA Program, you may start or stop an election or increase or decrease an election under that Program at any time by turning in a form for that purpose prescribed by the Employer. Such election shall be effective prospectively at the later of the date you specify on the request form or as soon as administratively feasible after the Employer receives the request form.

A Status Change Form is available from your employer. That form must be used to change your election during the middle of a Plan Year.

“USE IT OR LOSE IT”

This is a key point you must understand: If you have set aside dollars through salary reduction in the Uninsured Health Expense Reimbursement Program and/or the Dependent Care Assistance Program, and you do not use those dollars by the end of the Plan Year, **you will lose those dollars.**

Therefore, it is important to consider reducing your salary only to pay expenses you are sure you will incur during the Plan Year. Examples of the types of expenses that you know you will incur are regular expenses for items such as braces, insulin or other recurring drug expenses, office visit co-pay charges and weekly or monthly dependent care expenses.

Contributions allocated to one account under a benefit program can only be used to pay claims for that benefit program and no other. For example, amounts credited to your Dependent Care Spending Account cannot be used to pay or reimburse you for a medical expense under the Uninsured Health Expense Reimbursement Program, even

if your Dependent Care Spending Account has money in it but your account Uninsured Health Expense Reimbursement Account has none. Similarly, amounts credited to your Uninsured Health Expense Reimbursement Account cannot be used to pay or reimburse you for a dependent care expense under the Dependent Care Assistance Program, even if your Uninsured Health Expense Reimbursement Account has money in it but your Dependent Care Spending Account has none.

THE PLAN CAN BE CHANGED

The Plan is intended to comply with all applicable sections of the Internal Revenue Code and specifically Section 125; therefore, the Plan and any benefit programs offered under the Plan may be amended to comply with the Internal Revenue Code and the Treasury Regulations as they may be amended. In addition, the Plan and any benefit programs offered under the Plan may be amended at any time for reasons other than compliance with new law. Your employer may also terminate the Plan or any benefit programs offered under the Plan at any time as specified in the Plan document.

HOW TO FILE A REIMBURSEMENT REQUEST

If you have a claim under an insurance policy or plan underlying one of the Insurance Premium Programs (for example, a claim under the Employer's group health insurance plan, whose premiums are paid under this Plan through the Group Health Insurance Program), you should follow the claims procedure applicable to that plan or policy, as described in the applicable plan document or summary. For claims associated solely with the Plan, you should file your claim for reimbursement as soon as possible after you have incurred the expense. You must complete and sign a "Request for Reimbursement Form" for all requests that you submit. Your claim for expense reimbursement must include the following:

- a. A statement from your service provider that you have incurred the expense and the amount of your expense; and
- b. A signed "Request for Reimbursement Form."

You must send the completed form, together with the statement from your provider, to your Employer's representative -- Manley Services Co., P.O. Box 70168, Eugene, OR 97401. Claims for reimbursement submitted after the allowable year-end "run out" period, defined in the Summary Plan Description section entitled "PLAN INFORMATION SHEET," will not be paid. You will also have only the same run-out period after the date you terminate employment or otherwise cease to be eligible in which to obtain reimbursement for expenses incurred before that date (except under the Dependent Care Assistance Program, as explained in the section of this Summary Plan Description describing that program).

HANDLING DENIED CLAIMS

It is possible that a claim under the Plan may be denied. For example, the Plan Administrator could deny a reimbursement request under the Uninsured Health Expense Reimbursement Program or the Dependant Care Assistance Program. In

addition, you could be denied a benefit under the Plan for reasons relating to your ability to obtain Plan coverage. An example of this would be the Plan Administrator's denial of your ability to change your existing pre-tax elections due to a "change in status."

If the Plan Administrator denies a claim, in whole or in part, you will be notified in writing within 30 days of the date the Administrator receives your claim. (The 30-day period may be extended for an additional 15 days for matters beyond the Administrator's control, such as situations where a claim is incomplete.) The Plan Administrator will provide written notice of any extension, describing the reasons for the extension and the date by which you can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by the Administrator and allow you 45 days from receipt of the notice to provide the additional information. (If this happens, it will have the effect of suspending any decision on your claim until you provide the specified information.)

If the Plan Administrator denies your claim, you will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information you would need to validate your claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including your right to submit written comments, 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

You may appeal a claim denial by submitting a Request for Review (or other written appeal request) to your Employer's Plan Administrator or its designated agent within 180 days of the date of notice of your claim denial. 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, and should include any additional items or information that you feel supports your claim. The appeal process will provide you with 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.

To the extent a dispute arises under the terms of one of the insurance programs, such as a group medical or dental insurance program offered by your Employer, your ability to appeal decisions under the insurance program will be outlined in the Summary Plan Description or similar explanatory booklet available from the insurer.

The Plan Administrator will review your appeal in a reasonable time, but no later than 60 days after receiving your request. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. If the Plan Administrator consults with a medical expert to help analyze your appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. In addition, the Plan Administrator will provide you with the identity of any medical experts consulted. If upon review a decision is reached to affirm the original denial of your claim, you will receive a notice of that determination, which will include the following elements:

- The specific reason or reasons for the decision on review;
- The specific Plan provision or provisions that motivated the decision;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If “internal rules, guidelines, protocols, or other similar criteria” (collectively referred to as “internal guidelines”) are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

ERISA RIGHTS

As a participant in the Flexible Spending Account Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act (“ERISA”).¹ ERISA provides that plan participants are entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work-sites and union halls, all plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

¹ ERISA does not apply to employee benefit plans sponsored by governmental entities or churches. If your employer is a church or governmental organization (such as a city or school district), ERISA will not apply and you will not have the rights described in this section. ERISA also does not apply to the Plan as a whole or the benefit programs other than the Uninsured Health Expense Reimbursement Program. ERISA does apply to the Uninsured Health Expense Reimbursement Program and some or all of the plans underlying the Insurance Premium Programs.

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

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 you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit 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 Pension and Welfare Benefits Administration.

COBRA AND HIPAA RIGHTS

You may have a right to continue your coverage under insurance policies or plans underlying the Insurance Premium Programs if the insurance policies or plans constitute group health plans. In some cases, COBRA rights may also extend to the Uninsured Health Expense Reimbursement Program if offered under the Plan. These continuation rights are known as “COBRA,” and apply if your coverage terminates in certain circumstances. See the underlying component plan documents, summary descriptions and COBRA notices for more information concerning your COBRA rights.

You may also have rights regarding the reduction and elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, provided

you have creditable coverage from another plan. These rights are controlled by a law known as "HIPAA." More information is available from your Employer and in the group health plan documents and summary descriptions.

NOTICES REQUIRED BY LAW:

- a. The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- b. A group health plan, and a health insurance issuer providing health insurance coverage in connection with the group health plan, that provides medical and surgical benefits with respect to a mastectomy (including the Medical Expense Reimbursement Program forming a part of the Plan), shall provide, in a case of a participant beneficiary who is receiving benefits in connection with the mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

reconstruction of the breast on which the mastectomy has been performed,

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient. Such coverage is available under the Medical Expense Reimbursement Program; provided, however, that such coverage is subject to all limitations and requirements established for the other benefits under the Medical Expense Reimbursement Program.