Resolution Adopted by
Thomas County Board of Education

The undersigned, being all of the members of the Thomas County Board of Education, hereby adopt the following resolutions by unanimous consent and direct that this Consent Resolution be entered in the minutes.

WHEREAS:
A Thomas County Schools (the Employer) hereby amends the Thomas County Schools Cafeteria Plan (the Plan) effective January 1, 2014 (the Effective Date) to allow participants to carry over $500 of unused FSA funds to their FSA balance from a current plan year for the subsequent plan year as permitted by IRS Notice 2013-71. This will also remove the two and half month grace period from the plan once the carryover is added as stated in Notice 2013-71. The carryover of up to $500 does not impact the maximum subsequent plan year FSA election amount set by law. This is effective for the 2014 plan year.

B. The Employer determines that the above actions are in the best interests of the Plan;

NOW, THEREFORE, BE IT RESOLVED that:

1. The School Board hereby adopts to amend the Plan, effective as of January 1, 2014;

2. The School Board officers are authorized and directed to take any and all action as may be necessary to effectuate this Resolution.

IN WITNESS WHEREOF, the undersigned have executed this Consent Resolution effective as of January 1, 2014.

Signature – Board Chairman — Date: 1-14-14

Signature – Board Secretary — Date: 1-14-14

Thomas County Schools Cafeteria Plan
Summary of Material Modifications

As of January 1, 2014, the Thomas County Schools Cafeteria Plan (the Plan) is hereby amended to allow participants to carry over $500 of unused FSA funds to their FSA balance from a current plan year for the subsequent plan year as permitted by IRS Notice 2013-71. The carryover of up to $500 does not impact the maximum subsequent plan year FSA election amount set by law.

The Plan is hereby amended to allow participants to carry over $500 of unused FSA funds to their FSA balance from a current plan year for the subsequent plan year as permitted by IRS Notice 2013-71. The $500 rollover will begin on January 1, 2014 plan year and will apply to unused amounts remaining in your Health FSA Accounts on December 31, 2014.

In order to take advantage of the carry over provision under the Health FSA, you must be:

- A participant with Health FSA coverage that is in effect on the last day of the Plan Year
- A participant with Health FSA coverage with a balance of $500 or less at the end of the year.
- A participant with Health FSA coverage in the subsequent plan year

There is No Cash-Out or Conversion. Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

Run-Out Period and Forfeitures. Claims for reimbursement of Medical Care Expenses incurred during a Plan Year must be submitted no later than the 60 days following the close of the Plan Year in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts of $500 or less that remain after all reimbursements have been made for the Plan Year shall be carried over to subsequent plan year as permitted by IRS Notice 2013-71.

Please attach this document to your SPD for future references. If you have questions, contact Human Resources at 229-225-4380.

Thomas County Schools

Cafeteria Plan
Summary Plan Description

As Amended: January 1, 2013

Introduction

Thomas County Schools (the Employer) sponsors the Thomas County Schools Cafeteria Plan (With Premium Payment, Health FSA, HSA, Premium Reimbursement Plan and DCAP Components) (the Cafeteria Plan) that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. (Such plans are also known as cafeteria plans.) Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

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

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

An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer (ask the Human Resources Manager for a copy if you have not received one). Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

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

The Cafeteria Plan includes the following components:

- *Premium Payment Component (Medical, Dental and Vision Insurance Benefits)*—permits an Employee to pay for his or her share of contributions for the Medical, Dental and Vision Insurance Plans with pre-tax dollars.

  — Medical Insurance Plan means the major medical plan that the Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy. Here, these benefits include health maintenance organization (HMO) and preferred provider organization (PPO) options, as well as a high deductible health plan (HDHP). Benefits provided under the Medical Insurance Plan are called Medical Insurance Benefits.
  — Dental Insurance Plan means the dental plan that the Employer maintains for Employees, their Spouses, and their Dependents, providing dental type benefits through a separate group insurance policy. Benefits provided under the Dental Insurance Plan are called Dental Insurance Benefits. Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called Premium Payment Benefits.
  — Vision Insurance Plan means the Vision plan that the Employer maintains for Employees, their Spouses, and their Dependents, providing Vision type benefits through a separate group insurance policy. Benefits provided under the Vision Insurance Plan are called Vision Insurance Benefits. Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called Premium Payment Benefits.

- *Health Flexible Spending Arrangement (Health FSA) Component*—permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits

provided under the Health FSA are called Health FSA Benefits. As described in Q-22, the Health FSA election may be for:

— General-Purpose Health FSA Coverage;
— Limited (Vision/Dental/Preventive Care) Health FSA Coverage;
— Employee-Only Health FSA Coverage; or
— Employee-Plus-Children Health FSA Coverage.

- *Health Savings Account (HSA) Component*—permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian. Benefits provided under the HSA, which consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis (see Q-28), are called HSA Benefits.
- *Dependent Care Assistance Program (DCAP) Component*—also called a dependent care flexible spending account—permits an Employee to pay for his or her qualifying Dependent Care Expenses (as described in Q-41) with pre-tax dollars. Benefits provided under the DCAP are called DCAP Benefits.

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

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

Full time employees who are working 20 or more hours per week are eligible to participate in the Cafeteria Plan (including Premium Payment Benefits for Medical, Dental and Vision Insurance, Health FSA Benefits, HSA Benefits, and DCAP Benefits) following 30 days of employment with the Employer, provided that the election procedures in Q-5 are followed. Eligibility for the Medical, Dental and Vision Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Medical, Dental and Vision Insurance Plan. Eligibility for HSA Benefits also requires that you be an HSA-Eligible Individual. See Q-28 for additional information.

An Employee is an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include the following: (a) any common-law employee who is a leased employee or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee even if such an individual is later reclassified as a common-law employee; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency; (c) any employee covered under a collective bargaining agreement; or (d) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

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

You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Medical Insurance Benefits under the Cafeteria Plan. Suppose that you are married and have one child and that your share of the required contributions for Medical Insurance Benefits for family coverage is an annual total of $6,400. Suppose also that your gross pay is $75,000, your Spouse (a student) earns no income, and you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce $6,400 to pay for the Medical Insurance contributions, then your annual take-home pay would be $57,252. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,802. This is because by participating in the Cafeteria Plan for Medical Insurance contributions, you will be considered for tax purposes to have received $68,600 in gross pay, so you save $1,450. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions

also lower earned income, which can impact the earned income credit for eligible taxpayers. **Caution:** The amount of the contributions used in this example is not meant to reflect your actual contributions—the actual contribution amounts will be described in a document provided separately to you by the Employer.

	Cafeteria Plan*	**No Cafeteria Plan**
1. Adjusted Gross Income	$75,000	$75,000
2. Salary Reductions for Premiums	($6,400)	$0
3. W-2 Gross Wages	$68,600	$75,000
4. Standard Deduction	($11,400)	($11,400)
5. Exemptions	($10,950)	($10,950)
6. Taxable Income (line 3 minus lines 4 & 5)	$46,250	$52,650
7. W-2 Gross Wages	$68,600	$75,000
8. Federal Income Tax (line 6 @ tax schedule)	($6,100)	($7,060)
9. FICA Tax (7.65% of line 3)	($5,248)	($5,738)
10. After-Tax Premium Payments	$0	($6,400)
11. Pay After Taxes and Premium Payments (line 7 minus lines 8, 9 & 10)	$57,252	$55,802

* Based on the standard deduction, exemptions, and federal income tax rates for 2010, as found in IRS Rev. Proc. 2009-50 , 2009-45 I.R.B. 167. The FICA tax rate is found at http://www.ssa.gov/pressoffice/factsheets/colafacts2010.htm (as visited Nov. 8, 2010).

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

After you satisfy the eligibility requirements described in Q-3, you become a Participant by elect an individual Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. You must complete the Election Form/Salary Reduction Agreement and return it to the Human Resource Office within the time period specified in the enrollment materials. (If you have not received the enrollment materials and/or the Election Form/Salary Reduction Agreement, ask the Human Resources Manager for copies.) An eligible Employee who fails to complete, sign, and file an Election Form/Salary Reduction Agreement as required will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a Change in Election Event occurs, as explained in Q-7).

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

See Q-8 and Q-12 for information about how termination of participation affects your Benefits.

Q-6. What is the Open Enrollment Period and the Plan Year?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Cafeteria Plan by signing and returning an individual Election Form/Salary Reduction

Agreement. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period, which for a Plan Year generally will be two weeks in October of the previous Plan Year.

The Plan Year is the 12 months beginning on each January and ending on December 31st. The Plan Year is the same for the Cafeteria Plan, the Health FSA, PRA and the DCAP.

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

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

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code (the Code), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

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

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

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-24. For reimbursement of expenses from the DCAP Account after termination of employment.

For purposes of pre-taxing COBRA coverage for Medical, Dental and Vision Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See Q-12.

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

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in Q-3 before again becoming eligible to participate in the Plan.

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

No. The cost is paid in part by the use of forfeitures, if any (see Q-26 The rest of the cost of administering the Cafeteria Plan is paid entirely by the Employer.

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

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

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

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

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

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

Notification of a denied claim will set out:

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

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

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

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

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

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

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

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

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

FMLA Leaves of Absence. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical, Dental and Vision Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical, Dental and Vision Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

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

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

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

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

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see the attachment entitled “When Can I Change Elections Under the Cafeteria Plan During the Plan Year?” found at the end of this Summary).

Q-15. What are Premium Payment Benefits?

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

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

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

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

Q-17. What are Health FSA Benefits?

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

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

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Q-18. What is my Health FSA Account?

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

A Health FSA election may be for:

(a) General-Purpose Health FSA Coverage;
(b) Limited (Vision/Dental/Preventive Care) Health FSA Coverage; or
(c) Employee-Only Health FSA Coverage; or
(d) Employee-Plus-Children Health FSA Coverage.

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

Q-19. What are the maximum and minimum Health FSA Benefits that I may elect?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the minimum reimbursement amount of $300.00 and the maximum reimbursement amount of $2,500 per Plan Year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

Q-20. How are my Health FSA Benefits paid for under the Cafeteria Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to be reimbursed up to $1,000 per year for Medical Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of $1,000 during the Plan Year. If you are paid bi-weekly, then your Health FSA Account would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

The Employer makes no contribution to your Health FSA Account.

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

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, suppose that you elected $1,000 of coverage and contributed to your Health FSA Account (as described in Q-20) during March and December—that means that by February 24 you would have contributed $153.84 ($38.46 times four pay periods). You haven't made any prior claims for reimbursement during the calendar year, but on February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at that point.

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

Your Health FSA election may be for:

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

Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In addition, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

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

(a) *General-Purpose Health FSA Coverage Option.* For purposes of the General-Purpose Health FSA Coverage Option, “Medical Care Expense” means expenses incurred by you, your Spouse, or your Dependents for “medical care” as defined in Code §213(d) . However, expenses for medicines or drugs other than insulin will not qualify as Medical Care Expenses unless the medicine or drug has been prescribed. Thus, over-the-counter (OTC) medicines or drugs such as aspirin, antihistamines, and cough syrup must be prescribed in order to qualify as Medical Care Expenses; to be reimbursed for an OTC medicine or drug, you must provide documentation that the item was prescribed (see Q-24). In addition, as described above, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month.
The following list specifies certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of medical care under Code §213(d) and other requirements for reimbursement under the Health FSA.
EXCLUSIONS:

- health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Medical or Dental Insurance Plan);
- long-term care services;
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (“cosmetic surgery” means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease);
- the salary expenses of a nurse to care for a healthy newborn at home;
- funeral and burial expenses;
- household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
- custodial care;
- costs for sending a problem child to a special Schools for benefits that the child may receive from the course of study and disciplinary methods;
- social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- bottled water;
- cosmetics, toiletries, toothpaste, etc.;
- uniforms or special clothing, such as maternity clothing;
- automobile insurance premiums;
- transportation expenses of any sort, including transportation expenses to receive medical care;
- marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- OTC medicines or drugs (other than insulin) that have not been prescribed;
- any item that doesn't constitute “medical care” under Code §213(d); and
- any item that isn't reimbursable under applicable regulations.

For more information about what items are—and are not—Medical Care Expenses, consult IRS Publication 502 (Medical, Dental and Vision Expenses) under the headings “What Medical Expenses Are Includible?” and “What Expenses Are Not

Includible?" But use IRS Publication 502 with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in IRS Publication 502 aren't correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code §213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA. And not all expenses that are reimbursable under a Health FSA are deductible. For example, Health FSAs may reimburse OTC drugs if they qualify as medical care under Code §213(d) and have been prescribed, but they are still not deductible under Code §§213(a) and 213(b) .
Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

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

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

(c) *Employee-Only Health FSA Option.* For purposes of the Employee-Only Health FSA Option, Medical Care Expenses means the expenses described under the General-Purpose Health FSA Option (see subsection (a) above), provided that the expenses were incurred only by you (as the Participant) and not by your Spouse or your Dependents. If your Spouse maintains an HSA or wishes to establish an HSA, your participation in the General-Purpose Health FSA Coverage Option described in subsection (a) above will cause your Spouse to be ineligible for an HSA. By electing the Employee-Only Health FSA Option, you can essentially retain general-purpose health FSA coverage for yourself while leaving open the possibility that your Spouse may be able to contribute to his or her own HSA. No expense incurred by your Spouse or your Dependents will be reimbursed under this Health FSA to the extent that such expenses were incurred after you made the election to restrict coverage. When you submit a claim for reimbursement, you must certify that the expenses submitted for reimbursement were incurred by you.
(d) *Employee-Plus-Children Health FSA Option.* For purposes of the Employee-Plus-Children Health FSA Option, Medical Care Expenses means the expenses

described under the General-Purpose Health FSA Option (see subsection (a) above), provided that the expenses were incurred only by you (as the Participant) or your child who also qualifies as your Dependent (and not by your Spouse). If your Spouse maintains an HSA or wishes to establish an HSA, your participation in the General-Purpose Health FSA Coverage Option described in subsection (a) above will cause your Spouse to be ineligible for an HSA. By electing the Employee-Plus-Children Health FSA Option, you can essentially retain general-purpose health FSA coverage for yourself and your children while leaving open the possibility that your Spouse may be able to contribute to his or her own HSA. No expense incurred by your Spouse (or a Dependent who is not your child) will be reimbursed under this Health FSA to the extent that such expenses were incurred after you made the election to restrict coverage. When you submit a claim for reimbursement, you must certify that the expenses submitted for reimbursement were incurred by you or your child who qualifies as your Dependent.
For purposes of the Health FSA and its Coverage Options, Spouse means the person who is legally married to you and is treated as a spouse under the Code. Dependent means (1) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year, and (2) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. See the Plan Administrator for more information about which individuals will qualify as your Dependents.

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

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Cafeteria Plan—it is the 12-month period beginning on January 1st and ending on December 31st.

A Medical Care Expenses incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Cafeteria Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage, as described in Q-12).

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

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

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control—see Q-11). Claims will be paid in the order in

which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

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

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense (as defined in Q-23) and that it is not being paid for or reimbursed from any other source.

The Employer implemented an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA; some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information about the electronic payment card offered and the terms of the card.

The Health FSA can be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43 , IRS Notice 2006-69, or other IRS guidance.

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

Yes. If the Medical Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount—this is called the use-or-lose rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year, even if amounts are still left in your Health FSA Account. The difference between what you elected and what Medical Care Expenses were reimbursed will be forfeited at the end of the time limits described in Q-26. This plan has adopted a two and half month grace period. Medical expenses during this grace period can be applied to prior-year deferrals to avoid forfeitures.

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

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted no later than 90 days following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date—see Q-24). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

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

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

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

Q-28. What are DCAP Benefits?

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

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

Q-29. What is my DCAP Account?

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

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

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of $300 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in DCAP Benefits, you'll pay for the benefits with a $3,000 salary reduction).

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

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

- you are single or the head of the household for federal income tax purposes.

If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code §129 is $2,500 for a calendar year.

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

Q-31.How are my DCAP Benefits paid for under the Cafeteria Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for $2,600 per year for Dependent Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. Your DCAP Account would be credited with a total of $2,600 by the end of the Plan Year. If you are paid biweekly, then your DCAP Account would reflect that you have paid $100 ($2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

The Employer makes no contribution to your DCAP Account.

Q-32. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. Using the example in Q-39, suppose that you incur $1,500 of Dependent Care Expenses by the end of March 2011. At that time, your DCAP Account would only have been credited with $700 ($100 times seven pay periods), so only $700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining $800 in Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account (you could request a $100 reimbursement after each of the next eight pay periods).

Q-33. What are Dependent Care Expenses that may be reimbursed?

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

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:

  — a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or

stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
— your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
— a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition).
Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center—that is, a facility (including a day camp) that receives payment for providing care to more than six nonresident individuals on a regular basis—the center must comply with all applicable state and local laws.
- The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person for whom you (or your Spouse) are entitled to a personal exemption under Code §151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.
- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):

  — expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer Schools and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);
  — the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
  — expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided—e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

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

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

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

- your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);
- the earned income of your Spouse for the calendar year (note that a Spouse who is physically or mentally incapable of self-care or a full-time student is deemed to have earned income of a specified amount—see the Plan Administrator for more information); or
- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further in Q-38.

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

Q-34. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as for the Cafeteria Plan—it is the 12-month period beginning on January 1st and ending on December 31st.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Cafeteria Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described in Q-43).

Q-35. What must I do to be reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent

Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

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

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

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in Q-42) and that it is not being paid for or reimbursed from any other source.

Q-36. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account—this is called the use-or-lose rule under applicable tax laws. (No grace period is provided under the DCAP.) In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described in Q-45.

Q-37. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year no later than 90 days following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 90 days after the date you ceased to be eligible—see Q-43). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any DCAP Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Q-38. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-38. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims

that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

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

Q-39. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see Q-48). For example, if you elect $2,000 in coverage under the DCAP and are reimbursed $2,000, but you had Dependent Care Expenses totaling $4,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

Q-40. What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be you may take into account $2,400 of such expenses for one Qualifying Individual, or $4,800 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of $720 for one Qualifying Individual, or $1,440 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of $480 for one Qualifying Individual, or $960 for two or more Qualifying Individuals). The maximum 30% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $10,000. Note that these figures may increase/decrease based on provision changes of the Dependent Care Tax Credit.

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

Q-41. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?

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

Ask the Plan Administrator if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that the Plan Administrator is not providing legal advice. Your Employer may also be able to provide you with a worksheet or tax calculator to help you make the comparison—ask the Human Resources Manager if you would like to use one or both of

these. But if you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-42. What are my ERISA Rights?

The Cafeteria Plan and the HSA and DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Medical, Dental and Vision Insurance Plans are governed by ERISA. Note: This Summary Plan Description does not describe the Medical or Dental Insurance Plans. Consult the Medical, Dental and Vision Insurance Plan documents and the separate Summary Plan Descriptions for the Medical, Dental and Vision Insurance Plans. This Summary Plan Description also does not describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

Your Rights

As a participant in the Cafeteria Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

COBRA and HIPAA Rights

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note: This does not apply to the Dental Insurance Plan or Health FSA, which are “excepted benefits” under HIPAA.)

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

HIPAA Privacy Rights

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

Q-43. What other general information should I know?

This Q-43 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Medical or Dental Insurance Plans. Consult the Medical, Dental and Vision Insurance Plan documents and the separate Summary Plan Descriptions for the Medical, Dental and Vision Insurance Plans. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

Name:	Thomas County Schools
Plan Number:	501
Effective Date:	January 1, 2013
Plan Year:	01/01/-12/31. Your Plan's records are maintained on this 12-month period.
Type of Plan:	Welfare plan providing Medical Insurance Benefits, Health FSA Benefits, Premium Reimbursement Account, Health Savings Accounts and DCAP Benefits.

Employer/Plan Sponsor Information:

Name and Address:	Thomas County Schools 200 North Pinetree Boulevard Thomasville, GA 31792
Tax Id:	58-6000328

Plan Administrator:

Name and Address:	Joey Holland Thomas County Schools 200 North Pinetree Boulevard Thomasville, GA 31792
Phone:	(229) 225-4380 ext 112
Email:	hollandj@rose.net

Third Party Administrator:

Name and Address:	Consolidated Admin Services, LLC P.O. Box 1513 Cabot, AR 72023
Phone:	501-941-5956
Fax:	877-641-5956
Email:	cstout@consolidatedadmin.com

• The Plan Administrator appoints the Third Party Administrator to keep the records for the Plan and to be responsible for the administration of the Plan.

Funding Medium and Type of Plan Administration.

• The Health FSA Component is a group health plan. The health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Thomas County Schools, 200 North Pinetree Boulevard, Thomasville, GA 31792

Qualified Medical Child Support Order

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

Medical, Dental and Vision Insurance Plan and Information

This Summary Plan Description does not describe the Medical, Dental and Vision Insurance Plans. Consult the Medical, Dental and Vision Insurance Plan documents and the separate Summary Plan Descriptions for the Medical, Dental and Vision Insurance Plans.

Attachment 1

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

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

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

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

2. Change in Status. *(Applies to Medical, Dental and Vision Insurance Benefits, Health FSA Benefits (as limited below), and DCAP Benefits.)* If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

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

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

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year. (See also Q-20 and Q-21.)

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

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the Medical, Dental and Vision Insurance Plans and Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See Q-12.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your

Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

- *DCAP Benefits*. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

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

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits, but Not to Dental Insurance, Health FSA, or DCAP Benefits.)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

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

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

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

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

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

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

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

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

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

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

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

educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.
- *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.