The BESTflex℠ Plan

Summary Plan Description

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Pay less for your health and daycare expenses with The BESTflex℠ Plan.

Welcome to the BESTflex Plan Summary Plan Description (SPD)

This booklet provides a full overview of the BESTflex Plan. It covers various aspects of the plan, from enrollment and reimbursement to the different accounts of the plan and your rights under applicable federal regulations. We recommend you review this booklet and all documents that supplement it before enrolling in the BESTflex Plan.

The BESTflex Plan and Employee Benefits Corporation

The BESTflex Plan is an IRS-approved cafeteria plan governed by Internal Revenue Code (IRC) Section 125, providing special, tax-free benefits. You place funds from your paycheck into Flexible Spending Accounts (FSAs) to pay for health care expenses not covered by regular health insurance and your dependent care expenses. Each time you pay out of pocket for an eligible expense, you submit a claim and the BESTflex Plan reimburses you.

The plan also lets you pay for your group health premiums on a pre-tax basis.

Because the money you elect to place into the BESTflex Plan is deducted from your paycheck on a pre-tax basis, you pay less taxes. Apply these tax savings to your health care and daycare expenses, and you pay less for these expenses.

Some Additional BESTflex Plan Benefits

Quick reimbursement turnaround time: Your reimbursement check can be mailed to you or directly deposited into your bank account.

Comprehensive account information: Our website, www.ebcflex.com, offers secure access to your account information with My Account Assistant. You can also listen to your account information with our Telephone Account Assistant by dialing 800 346 2126 or 608 831 8445 with a touch-tone phone.

Participant Services Team: Our Participant Services Team is available to answer your questions by phone at 800 346 2126, Mon.- Fri., 8:00- 5:00 CST, or by e-mail at participantservices@ebcflex.com.

Remember, our job is to help you get the most from your BESTflex Plan.

About Employee Benefits Corporation

Employee Benefits Corporation is 100 percent employee-owned. As owners, the priority of each team member is to contribute to the success of your plan.

We are not your insurance carrier. We manage your employer's BESTflex Plan and process your claims associated with the eligible expenses you incur.

Understanding the SPD and My Company Plan

This SPD covers the basic aspects of the BESTflex Plan. Your employer may have selected additional BESTflex Plan options and features, which are explained on a separate appendix to the SPD called *My Company Plan.* ***My Company Plan*** **can include benefits not covered in this document.**

Your employer distributes a copy of *My Company Plan* and any documents specific to your plan design during your Open Enrollment Period. Once you enroll, these documents and forms specific to your plan design are available online. You use *My Company Plan* to help you complete your enrollment and understand the specific benefits offered as part of your company's plan design.

My Company Plan Contains:

A. The plan's effective date, the date your employer started its BESTflex Plan

B. Your plan year, the start and end dates of your company's current BESTflex Plan and the dates between which you can normally submit claims

C. Eligibility definitions

D. Group Insurance Premiums, the types of premiums deducted from your paycheck on a pre-tax basis

E. The Health Care and Dependent Care FSA contribution limits, the maximum amount you can contribute to each account

F. Plan Amendments, if any

G. Contact information for your employer

H. Legal Information defining the relationship between your employer and Employee Benefits Corporation

Enrolling in the BESTflex Plan

Enrollment in the BESTflex Plan lasts for one plan year, usually consisting of 12 calendar months or less.

During a specific period of time prior to the start date of the plan year – called the Open Enrollment Period – you determine your elections, the total amount you'd like withheld from your pay in the upcoming plan year. A deadline for the Open Enrollment Period is established by your employer.

Your employer can choose one of several enrollment methods. Regardless of the type your employer chooses, you decide how much of your pay to place in the accounts that apply to you.

Enrollment Process

1. Choose the account(s) that best fits your needs: the Health Care FSA and/or the Dependent Care FSA; consult *My Company Plan* and any accompanying documents to determine if other election opportunities are available under your company's plan design

2. Multiply the amount you'd like deducted from your paycheck by the number of paychecks you receive per year to determine your annual election

3. Total the per-paycheck deduction for each FSA to determine the amount withheld from each paycheck; consult *My Company Plan* to determine the types of Group Insurance Premiums that will also be withheld

If you are newly hired and would like to enroll in the BESTflex Plan mid-year, please refer to *My Company Plan* for eligibility information.

You must enroll in the BESTflex Plan each year you plan to participate.

Note: Your Plan Start Date may be different than what is listed in My Company Plan. Please see your HR Department for more information.

Direct Deposit Authorization

When you enroll in the BESTflex Plan, you have the option of having Employee Benefits Corporation deposit your reimbursements directly into your financial institution checking or savings account. Because you're responsible for paying the reimbursed amount to your provider, Direct Deposit saves you time and makes paying providers easier. It also eliminates the possibility of losing a reimbursement check and having to pay a stop-payment fee for a new check.

When you complete your *Enrollment Form*, be sure to include your e-mail address. We'll send you an e-mail notification of deposit.

To sign up for Direct Deposit, fill out the appropriate financial account information during your enrollment.

After You're Enrolled

The amounts you specified on your *Enrollment Form* are credited to your account(s). Check your pay stub to ensure the withholding amounts are correct.

You can now begin submitting claims.

Claim Forms as well as other forms and materials that support your using the BESTflex Plan are available on our web site at www.ebcflex.com.

Submitting Claims and Reimbursement

Submitting a Claim:

Online

1. Visit our website at www.ebcflex.com
2. Log into My Account Assistant
3. Complete the short web form and upload the scanned documentation
4. Review, submit and print your confirmation

Smart Phone

1. Available for iPhone and Android
2. Download the Employee Benefits Corporation Mobile Account Assistant app if you haven't already
3. Simply complete the Claim Screen, attach the receipt and submit

Manual Submission

1. Download the *Claim Form* from our website at www.ebcflex.com
2. Attach supporting documentation
3. Mail or fax *Claim Form* and supporting documents to Employee Benefits Corporation

Incurring Expenses

Your documentation must include:

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

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

About incurring expenses

An expense is incurred at the point of sale, not when the expense is billed or paid. You may incur expenses within the plan year and have up to 3 months after the end of the plan year to request reimbursement.

Expenses incurred before your plan effective date are not eligible.

Note: Please review My Company Plan to verify the number of days available for you to submit claims under your company's BESTflex Plan.

The Accounts of the BESTflex Plan

There are three basic accounts that make up the BESTflex Plan. Please review *My Company Plan* for the accounts available under your company's plan design.

There are two very important IRS rules that you must follow in order to use the BESTflex Plan:

1. You cannot cancel participation in the BESTflex Plan or change the amount of your payroll withholding during the plan year unless certain events occur
2. You must use all of the money in each of your FSAs by the end of the plan year or Grace Period. Any amount left over cannot be returned to you or carried over to the next plan year; funds remaining in your FSA must be returned to your employer. This is an IRS rule.

1. Group Insurance Premium Payments

Your employer already withholds money to pay for your medical or other group insurance premiums. With the BESTflex Plan, this withholding becomes an automatic, pre-tax deduction.

2. Health Care Flexible Spending Account (FSA)

The Health Care FSA is a health and welfare benefit plan governed by IRC 105 and 125. You use your Health Care FSA for out-of-pocket medical, vision, and dental expenses that are not covered by another health plan and that are incurred by you, your spouse, or your dependent(s) as defined in IRC 152 or your child(ren) as defined in IRC 152(f)(1) who has not attained age 27 as of the end of the calendar year. You decide how much pre-tax money to put into this FSA.

You are not eligible to make contributions to a Health Savings Account (HSA) if you or your spouse participate in the Health Care FSA.

Annual elections

Your annual election amount is the total of your election amount per paycheck multiplied by the number of paychecks in your plan year. Your employer withholds your election amount per paycheck from each paycheck. You may elect up to an amount elected by your employer. The maximum amount will be the lesser of an established maximum set by your employer or a statutory amount. See *My Company Plan* for the maximum election amount.

Estimate the total amount you want withheld during the plan year carefully. The IRS prohibits returning unused dollars to you. Careful planning can minimize having to return funds to the plan or having money left in the plan at plan year end.

Using the account

You can spend money from your Health Care FSA anytime during the plan year, whether the money has already been withheld from your paycheck or not. So, a large expense incurred early in the plan year can be reimbursed soon after you incur it, and the balance is then withheld from your paychecks throughout the plan year.

Note: IRC Section 213 defines expenses for "medical care" as amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Employee Benefits Corporation reimburses you for all eligible expenses as defined within the parameters of the regulations.

Orthodontia

Special rules exist regarding orthodontia reimbursement. Lump sum payments are only eligible when no other payment method is available. Your payment of the lump sum amount must be shown on the invoice.

If a payment plan arrangement is available, reimbursement will be based on the terms of the payment plan.

Over-The-Counter Drugs and Medicines

Over-the-counter drugs and medicines are only eligible with a prescription from your physician.

3. The Dependent Care Flexible Spending Account (FSA)

The Dependent Care FSA is a tax-free benefit plan governed by IRC Sections 129 and 125. You use your Dependent Care FSA for daycare expenses incurred for the care of your child(ren) or other eligible dependents. You (and your spouse, if you are married) must work or be a full-time student to use this account.

Annual elections

As with the Health Care FSA, you decide how much pre-tax money per paycheck to place into this account. Your employer withholds that election amount from each paycheck and it is deposited into your account.

We reimburse you from this account.

Using the account

The Dependent Care FSA differs from the Health Care FSA in that you can only be reimbursed for the amount of an incurred expense that is available in your account when you request reimbursement. Your current balance is the maximum reimbursement you can receive.

If you pay for daycare expenses and send in your *Claim Form* in advance, you are not paid until after the daycare service has been provided.

You should carefully estimate the total amount of pre-tax money you want withheld for the plan year. IRS rules prohibit returning funds remaining in the account to you once the plan year ends.

Note: You cannot apply the Federal Tax Credit for dependent care expenses to the amount you spend in this account.

Using IRS Form 2441

You are required to report both your federal tax credit and the BESTflex Plan dependent care pre-tax expenses, whichever applies, on IRS Form 2441. It is an attachment to your federal income tax return and you are required to list the name, address and tax identification number of your daycare provider. Contact Employee Benefits Corporation or your accountant if you have questions.

Note: Expenses for daycare services from centers having more than six individuals can only be reimbursed if the center complies with all state and local rules.

Expenses ELIGIBLE for reimbursement in the Dependent Care FSA:

A. Charges for daycare services outside your home for a "qualifying child" who is under the age of 13 and who depends on you (and your spouse, if you are married) for at least half of his/her support, does not have his/her own dependents, and is not a "qualifying child" of any other taxpayer during the year

B. Charges for care outside of your home for your spouse, dependent adult or child who is mentally or physically incapable of caring for himself or herself and has the same principal place of abode; the spouse or dependent must spend at least 8 hours of each day in your house

C. You may be reimbursed for expenses to provide care to the individual(s) described above in your home if the services are, at least in part, so you (and your spouse, if you are married) may work; the expenses include wages paid to the service provider, but not expenses such as food or clothing

Expenses INELIGIBLE for reimbursement in the Dependent Care FSA:

A. Schooling (Preschool is generally not schooling)

B. Overnight camps

C. Health care expenses

D Services provided by a person whom you or your spouse could claim as a deduction on your tax return or any of your children who are under age 19

E. Meals, supplies and materials

The Dependent Care FSA limits spending to a $5,000 maximum for married and head-of-household filers or $2,500 for those who are married and filing separately.

In general, if you file your income taxes as "single, head of household" or "married, filing jointly," you may be reimbursed for up to $5,000 per calendar year for dependent care expenses. If you are married and file a separate return, you may claim up to $2,500. However, you may not be reimbursed for more than the following amounts:

A. If you are single, your reimbursable limit is your net taxable pay (after all salary reductions for the BESTflex Plan and any other plans) for the year in which the expenses are incurred

B. If you are married and your spouse works, your reimbursable limit is the lesser of your net taxable pay or your spouse's taxable pay for the year in which the expenses are incurred

C. If you are married and your spouse is either a full-time student or is physically or mentally incapable of caring for himself or herself, your reimbursement limit is:

1. $250 in any one month if you have only one dependent
2. $500 in any one month if you have more than one dependent

FAQs

Q. How do I file a claim for reimbursement?

A. After the plan year begins, you may file a claim using a BESTflex Plan *Claim Form*. You can download forms from our website, www.ebcflex.com. After completing the form, attach its supporting invoices, receipts and/or Explanation of Benefits (EOB), and mail or fax them to Employee Benefits Corporation.

The supporting documentation must include the provider or point-of-sale name, the description of the services received or items purchased, the date service was received or purchase was made, and the amount of the expense.

Q. Can I pick and choose the accounts in which I'd like to participate?

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

Q. Can I decide not to use the BESTflex Plan at all?

A. Yes. If you decline participation, you will not be able to enroll in the BESTflex Plan until the following plan year unless you experience a qualifying event.

Q. Can I cancel or change my Group Premium or FSA election?

A. You cannot cancel or change these amounts during the plan year unless you experience a qualifying event. Please see "Events for Which You May Change Your Enrollment Elections" on page seven for more information.

Q. Can I transfer funds between different BESTflex Plan accounts?

A. No. Unused funds are not transferable.

Q. What happens if I don't use all of the money in my accounts by the end of the plan year?

A. The IRS requires that any money you do not use be returned to your employer. It cannot be returned to you or carried over to the next plan year. Your employer often uses the money to pay for the cost of administering the BESTflex Plan. If, near the end of the plan year, you have not spent all of the money in your accounts, you should look for other eligible expenses, on which you can spend the unspent portion. For example, any money left in your Health Care FSA could be used for a pair of prescription eye glasses or contact lens solution.

Note: While all expenses must be incurred during the plan year, you have a 3-month period after the plan year ends to request reimbursement for those expenses. Please review My Company Plan to verify the number of days available for you to submit claims under your company's BESTflex Plan.

Q. Can I spend the money in my FSAs anytime during the plan year?

A. The rules for the Health Care FSA are different than those for the Dependent Care FSA. The IRS allows you to spend the entire annual amount that you put into the Health Care FSA at any time during the plan year. You could, for example, get reimbursed for an expense equaling your annual contribution in the first month of the plan year, even though most of the money has not yet been withheld.

The Dependent Care FSA is different. You may use the money in this account only after it has been withheld from your paycheck and the dependent care expense has been incurred.

Q. What if my employment is terminated or I lose eligibility for the BESTflex Plan during the plan year?

A. **For the Health Care FSA:** If your employment is terminated or you lose eligibility, you can only submit claims for expenses incurred prior to your termination or loss of eligibility date.

You have the standard 3 month runout period to submit claims after your termination date. Please review *My Company Plan* to verify the number of days available for you to submit claims under your company's BESTflex Plan.

To receive reimbursement for expenses incurred after your termination date, you must elect Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation, which may require after-tax contributions to the plan.

For mid-plan year rehires or other questions, please contact your Human Resource Department or Employee Benefits Corporation.

For the Dependent Care FSA: If you terminate or lose eligibility, the contributions to your plan stop. You can continue to submit eligible expenses for daycare through the end of the plan year; however, you cannot contribute additional dollars after your termination date.

Note: The Grace Period does not apply to participants who terminate or lose eligibility before the end of the plan year.

Dependent and Child Definitions

Federal law requires group health plans that offer dependent coverage to make coverage available to children of a covered employee until age 26. Defining what constitutes a "dependent" or "child" varies. The section below explains the differences and how a particular definition can affect your BESTflex Plan.

Dependent Definitions for Health Plans

A "dependent" is someone who can have tax-favorable coverage under a health plan (including a Health Care FSA), and is defined as either a "qualifying child" or a "qualifying relative" as described below.

A "qualifying child" is someone who:

A. Is a child of the taxpayer (or a descendent of such a child), brother, sister, stepbrother or stepsister of the taxpayer, or a descendent of any such relative;

B. Is not yet 19 or is a student who is not yet 24 by the end of that year or is permanently and totally disabled at any time during the year;

Note: A student for this purpose must be a full-time student for at least five calendar months during the year.

C. Has not provided more than half of his/her own support in that year; and

D. Has the same principal place of abode as the taxpayer for more than half of the relevant calendar year.

Note: A child supported by a parent who lives with another relative (an aunt), is no longer a dependent of the taxpayer but could be a dependent of the relative.

Temporary absences due to illness, education, military service, and similar factors do not result in loss of residency with the taxpayer. A child attending college away from home could have the same principal abode as the taxpayer.

A "qualifying relative" is someone who:

A. Is a child of the taxpayer (or a descendent of such a child), brother, sister, stepbrother, stepsister, father, mother (or ancestor), stepmother, stepfather, niece, nephew, aunt, uncle, in-law (father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, or daughter-in-law) or who (other than a spouse) has the same principal place of abode as the taxpayer and is a member of his/her household (unless the relationship violates local law);

B. Receives half or more of his/her support in the year from the taxpayer; and

C. Is not a "qualifying child" of any taxpayer in the year.

Child Definitions for Health Plans

A "child" is someone who:

A. Is a son, daughter, stepson or stepdaughter of the taxpayer;

B. Is an eligible foster child of the taxpayer, or;

C. Is a legally adopted child of the taxpayer.

Qualifying Individual

The definition of a "qualifying individual" for purposes of a Dependent Care FSA is described below.

A "qualifying individual" is someone who:

A. Has not attained age 13 and is a "qualifying child," as defined above, for purposes of health plans, and

1. Does not have his/her own dependents, and

2. Is not a "qualifying child" of any other taxpayer during the year

B. Is a dependent who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than half the year (unless the relationship violates local law); or

C. Is the spouse, is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than half the year (unless the relationship violates local law).

Citizens or Nationals of Other Countries

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

Dependents in Cases of Divorce

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

Health Care FSA

For purposes of the Health Care FSA, the custodial parent with the right to the tax exemption may claim the child as a dependent if certain requirements are met.

In the case of the Health Care FSA, it can be the non-custodial parent if four requirements are met:

1. Parents are divorced, legally separated under a decree of divorce or separate maintenance, legally separated under a written agreement or have lived apart at all times during the last six months of the calendar year

2. Over half the child's support during the year comes from one or both parents

3. The child is in the custody of one or both parents for over half of the year

4. The child is a "qualifying child" or "qualifying relative" of one of the parents

Dependent Care FSA

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

Events for Which You May Change Your Enrollment Elections

Qualifying events are specific events that, when they occur, allow you to legally change your BESTflex Plan elections. You can also alter how your plan works if you take a leave of absence from work or take a military leave.

The IRS may allow you to change the amounts you set aside in your FSAs during the year, but only in the case of certain events. If one of the following events applies to you, inform your employer as soon as possible.

Changes to the plan must be made within 30 days of the event – 60 days for Children's Health Insurance Program (CHIP) events – and can only be made for a future date.

A. Change In Status Event results in you, your spouse, or your dependent gaining or losing coverage under the BESTflex Plan or a plan of your spouse's employer, and leads to an election change that corresponds with that gain or loss of coverage. There are two steps used to determine whether a change is permissible. First, a qualifying event must occur. Second, there must be a gain or loss of eligibility under the plan due to the event.

This category of events applies to all types of coverage under the plan.

The following events are changes in status:

1. **Marital status** - events that change your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment
2. **Number of dependents** - events that change the number of your dependent(s) for tax purposes, including birth, death or adoption
3. **Employment status** - events that include a termination or commencement of employment, a change in the number of hours worked, a strike or lockout, a switch between part-time and full-time or vice versa, a work site change, or the beginning or end of an unpaid leave of absence by you, your spouse, or your dependent(s)

   a. Employees terminated and rehired within 30 days are not considered to have experienced a qualifying event; therefore, any employee rehired within 30 days is reinstated at their prior annual elections

   b. Employees terminated and rehired after 30 days are not allowed to participate in the Reimbursement Accounts until the next plan year

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

   For example, an employee enrolls in the Health Care FSA after meeting eligibility requirements. During the plan year, the employee's hours are reduced below the minimum required to maintain eligibility. A change could be allowed since the change in status caused a change in eligibility for the benefit.

4. **Dependent eligibility** - events that cause your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or similar circumstances provided in the plan covering you
5. **Residence** - events that cause a change in your, your spouse's, or your dependent's place of residence and result in the gain or loss of eligibility under the plan; does not apply to the Health Care FSA

B. HIPAA Special Enrollment Event results in an election change corresponding with the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to individuals who lose other health insurance coverage or become the spouse or dependent of an employee through birth, marriage or adoptions. This applies only to health plans that are subject to HIPAA.

C. Court Order Event results in your election change corresponding to a court order regarding health coverage of your child. This event only applies to health, dental, and vision insurance or the Health Care FSA. You must be able to show that other coverage exists before you can drop coverage.

D. Entitlement to Medicare or Medicaid Event results in enrollment by you, your spouse, or your dependent allowing a decrease or cancellation of health coverage under the plan. Losing entitlement of Medicare or Medicaid may allow you, your spouse, or your dependent to increase or enroll in health coverage under the plan and applies only to health plans subject to HIPAA.

E. Change in Cost Event results when a provider under Group Insurance Premiums or the Dependent Care FSA increases or decreases the cost of coverage and your insurance premium payments automatically increase or decrease by the corresponding amount as a result. If you are enrolled in the Dependent Care FSA, you must submit a *Qualifying Event Election Change Form*. If the provider changes rates but is a relative, election changes cannot be made during the plan year. This event does not apply to the Health Care FSA.

F. Addition or Elimination of a Benefit Option results if the employer offers or ceases to offer a benefit package option. Participants may elect to add or revoke their election with respect to only that benefit. If there is an end of coverage, a participant may elect alternative coverage but may not revoke their election. This event does not apply to the Health Care FSA.

G. **Change in Coverage Under Any Employer's Plan** results when the employee's, spouse's, or the dependent's employer increases coverage, decreases coverage, or ceases coverage. This event allows participants to make or revoke an election change under the plan. Changes corresponding to new or waived elections can also be made during open enrollment under the other employer's plan. This event does not apply to the Health Care FSA.

H. **COBRA Events:** Participants may increase their pre-tax contributions under the employer's plan for coverage if a COBRA event occurs with respect to the employee, the employee's spouse, or the employee's dependent. Plans must be covered by COBRA or similar state continuation rules for these events to apply. The individual covered by COBRA must still qualify as a tax dependent of the employee to allow for pre-tax treatment of contributions.

I. **Loss of Other Coverage Under A Governmental or Educational Institution Plan:** Participants may make new elections under a health plan if you, your spouse, or your dependent lose coverage under a governmental or institutional plan. This event does not apply to the Health Care FSA.

J. **HSA Contributions:** You may start, stop, increase or decrease your HSA contributions at any time during the plan year, as long as the election change is prospective (i.e., after the request for the change is received). All changes become effective on the first of the month.

K. **Children's Health Insurance Program (CHIP):** You may make a new election if you and/or your dependent are enrolled under CHIP and lose eligibility for that coverage due to medical eligibility or you and/or your dependent become eligible for premium assistance under CHIP or Medicaid.

Contributions During Unpaid Family, Medical or Military Leave

If you are on unpaid leave under the federal Family and Medical Leave Act of 1993, but you elect to continue participation in Group Insurance premiums or the Health Care FSA of the BESTflex Plan, your employer may obtain your plan contributions for the leave period by having you either:

A. Prepay them, with your permission, from your last paychecks before the leave (on a pre-tax basis)

B. Pay as you go from your other financial resources (on an after-tax basis)

C. Pay them when you return from leave (on a pre-tax basis)

Your employer automatically deducts missed payments on return from leave.

Military Leave

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

Please contact your Human Resource Department if you have questions.

How the BESTflex Plan Affects Taxes and Insurance

How the Plan Affects Social Security Benefits

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

How the BESTflex Plan Affects Your Tax Return

When you receive your W-2 form at the end of the year, the gross amount of your income shown on the form is your gross income minus the amount withheld by your employer under the BESTflex Plan. This is the amount you use for gross income when you fill out your tax return. Your income tax is lower because it is based on a smaller gross income.

How the BESTflex Plan Affects Insurance Payments or Benefits

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

Operation of the BESTflex Plan

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

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

Subject to your rights, explained in the Statement of ERISA Rights on page 11 of this booklet, your employer's determinations shall be final, conclusive and binding on all parties.

Funding

The plan is funded by contributions that you elect to make from compensation received from your employer. Your employer may decide to make contributions as well. Please consult *My Company Plan* for details specific to your plan design.

HEART Act Distributions

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

Qualified Reservists may receive a Qualified Reservist Distribution from the balance of the Health Care FSA if:

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

The amount of the distribution from the Health Care FSA will be calculated by subtracting the amount reimbursed from the amount contributed through your salary reductions. You may only elect to receive a Qualified Reservist Distribution once per plan year. Further, your right to submit claims for the Health Care FSA terminates following the distribution.

Notice of Denials and Appeals

All claims and required documentation must be submitted no later than 90 days after the end of the plan year or your termination from employment. Please review *My Company Plan* to verify the number of days available for you to submit claims under your company's BESTflex Plan. Initial claims will be decided no later than 30 days from receipt of the claim.

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

If your claim is denied, you will receive a written notice citing the specific reasons for the denial and the plan provisions on which it is based. You are also provided with a description of any additional documents or material you might need to complete an incomplete claim.

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

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

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

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

If the appeal denial is based on any internal rule, guideline, protocol or other criterion, this rule, guideline, etc., is provided to you, free of charge, upon your request. You may obtain from Employee Benefits Corporation any relevant information regarding your claim. You may also have the right to sue in federal court under ERISA (Employee Retirement Income Security Act of 1974).

The claims and appeals process will be applied in a manner that complies with all applicable laws and regulations, including regulations under the Patient Protection and Affordable Care Act (PPACA) of 2010.

COBRA and the BESTflex Plan

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Health Care FSA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Qualified Beneficiaries (QBs) are individuals who have the same rights as active employees on the group health plan. QBs are generally employees, employees' spouses and employees' dependents, who were covered by the group health plan on the day prior to a COBRA qualifying event. QBs are also children who are born or adopted by the covered employee during the COBRA continuation period. These children must be added to the plan within 30 days of their birth or adoption. The newborn or adopted child will remain covered only for the period of time the other family members continue to be covered.

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

A. Your hours of employment are reduced, causing you to no longer be eligible for the Health Care FSA or your premium to increase for the same plan; or

B. Your employment ends for any reason other than your gross misconduct.

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

A. Your spouse dies;

B. Your spouse's hours of employment are reduced, causing you to no longer be eligible for the same group health plan(s) or your premium to increase for the same group health plan(s);

C. Your spouse's employment ends for any reason other than his/her gross misconduct;

D. Your spouse becomes enrolled on Medicare Part A, Part B or both; or

E. You become divorced or legally separated from your spouse.

If an employee drops his/her spouse from coverage in anticipation of divorce or other qualifying event before it actually happens, the ex-spouse must still be provided with COBRA notification. When the divorce or other qualifying event becomes final, the employer must be notified so the notification can be sent.

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

A. The parent-employee dies

B. The parent-employee's hours are reduced, causing the child to no longer be eligible for the same group health plan(s) or the child's premium to increase for the same group health plan(s)

C. The parent-employee's employment ends for any reason other than his/her gross misconduct

D. The parent-employee becomes enrolled in Medicare Part A, Part B or both

E. The parents become divorced or legally separated; or

F. The child stops being eligible for the coverage under the plan as a "dependent child."

■ COBRA Continuation Coverage is Temporary

Generally, COBRA continuation coverage under your employer's Health Care FSA will only be available, if at all, until the end of the plan year in which a qualifying event occurs. This is because an exception under federal law that limits COBRA continuation coverage for most Health Care FSAs. If this exception applies and you have overspent your FSA account when a qualifying event occurs, your employer is not required to offer you COBRA continuation coverage for your Health Care FSA.

You have "overspent" your Health Care FSA if the amount that remains in your FSA is less than the COBRA premium amount that your employer can charge you for your continued Health Care FSA coverage. You will only be offered COBRA continuation coverage that lasts through the end of the plan year if you have not overspent your Health Care FSA on the date the qualifying event occurs.

COBRA continuation rules regarding maximum continuation coverage periods of 18 months or 36 months (depending on the qualifying event) will not be applicable. COBRA continuation rules regarding second qualifying events, which can extend those coverage periods, will also generally not be applicable.

■ Notification of Qualifying Events and Paying for COBRA

COBRA continuation coverage will be offered to qualified beneficiaries only after your employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or a reduction in hours of employment, the death of the employee, or enrollment of Medicare (Part A, Part B or both), your employer must notify you, your spouse, and dependent(s) of the qualifying event:

A. Within 30 days of any of these events; or

B. Within 30 days following the date on which coverage ends

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

Once your employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin:

A. On the date of the qualifying event; or

B. On the date the group health plan coverage would otherwise have been lost.

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

A. The date you would lose coverage due to one of the above listed qualifying events; or

B. The date the COBRA election notice is provided to notify your employer that you want to continue coverage.

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

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

Each qualified beneficiary in a family may make separate, independent elections. A separate election simply means that family members can pick and choose coverage they wish to continue. COBRA regulations do not allow multiple plans to be continued under the same coverage. An example of what is not allowed would be taking two single health

policies instead of the QB & Spouse or Family health plan. The covered employee or spouse may elect for all dependents.

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

Under federal regulations, the employer can charge the COBRA continuation participants up to 102% of the premium to help offset the administration costs. Participants who have made separate elections during the disability extension can only be charged up to 102% of the premium.

The BESTflex Plan and ERISA

As a participant in the BESTflex Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Statement of ERISA Rights

ERISA provides that all participants are entitled to:

A. Examine, without charge, all documents of the BESTflex Plan and copies of all documents filed by the BESTflex Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions

B. Obtain copies of all documents of the BESTflex Plan and other information regarding the BESTflex Plan upon written request; there is a reasonable charge for copies

C. Receive a summary of the BESTflex Plan's annual financial report

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

Enforcement of ERISA

Under ERISA, there are steps you can take to enforce the above rights:

A. If you request materials from the BESTflex Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require your employer to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the employer's control

B. If you have a claim of benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court

C. 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 federal court. The court will decide who should pay 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 (for example, if your claim is found frivolous) the court may order you to pay these costs and fees.

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

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

HIPAA and Privacy

Summary of Privacy Practices

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

Protected Health Information

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

How Employee Benefits Corporation Uses PHI

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

Protecting your PHI is very important to Employee Benefits Corporation. As a participant in our benefit plans, you are trusting us with your private information. Be assured that this information will be kept confidential.

Pre-existing Condition Limitations

The BESTflex Plan does not contain any pre-existing condition limitations.

Portability

The Health Care FSA may not be subject to HIPAA's portability, Certificate of Credible Coverage requirement, nondiscrimination rules and full COBRA continuation beyond the end of the plan year if the following conditions are met:

A. **Maximum Benefit Condition.** The maximum benefit under the Health Care FSA cannot exceed two times the employee's salary reduction election for the Health Care FSA benefits for the year or, if greater, the amount of the employee's salary reduction election for the year plus $500, and

B. **Availability Condition.** Employees must have other coverage available under a group health plan of the employer and the other coverage cannot be limited to excepted benefits under HIPAA.

Questions or Concerns

Please contact your employer's privacy officer. You may also contact Employee Benefits Corporation's Director of Compliance 800 346 2126.

Termination and More Information

Assignment of Benefits

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

Keep Your Plan Informed of Changes

In order to protect you and your family's rights, you should keep your employer informed of any changes in address, marital status, or a child's status as a dependent under the group health plan's policy.

Termination of the BESTflex Plan

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

The Complete Plan Document

This is a summary description of the BESTflex Plan. The complete *Plan Document* is available from your employer. (If there is any inconsistency between this summary description and the *Plan Document*, the *Plan Document* is the most accurate resource.)

Contact Employee Benefits Corporation

Contact Employee Benefits Corporation if you have any questions about your BESTflex Plan.

E-mail: participantservices@ebcflex.com

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