Flexible Benefits Summary Plan Description For

Radiology Consultants of Iowa

Effective January 1, 2016

Restated January 1, 2026

CLAIMS ADMINISTRATOR

EMPLOYEE BENEFIT SYSTEMS
214 NORTH MAIN STREET
BURLINGTON, IA 52601
319-752-3200 800-373-1327 FAX 888-511-3743
www.ebs-tpa.com
contactus@ebs-tpa.com

SUMMARY PLAN DESCRIPTION

This document is intended to be a summary of the benefits and other terms and conditions of the IRC Section 125 Flexible Benefits Plan, as they are set forth in the plan document of that Plan. Your specific rights to benefits under the Plan are governed solely by the plan document. In all cases the terms and conditions of the plan document shall control, and shall supersede this summary plan description (SPD), including discrepancies between the plan document and this summary description. A copy of the plan document can be obtained from the Plan Administrator (as described below).

(1) What is the Plan Name? IRC Section 125 Flexible Benefits Plan (the "Plan")

(2) Who is the Employer?

Radiology Consultants of Iowa
1948 First Avenue NE
Cedar Rapids, IA 52402

(3) Who is the Plan Administrator?

The Employer is the Plan Administrator. Any interpretation of the provisions of the Plan or this SPD, and any decision on any matter within the discretion of the Plan Administrator, made by the Plan Administrator in good faith, shall be binding on all persons. A misstatement or other mistake of facts shall be corrected when it becomes known and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable.

The claims for benefits made by participants to the Plan are processed and administered on behalf of the Plan and the Plan Administrator by:

Employee Benefit Systems (EBS)
214 N. Main Street, Burlington, IA, 52601
Ph: 319.752.3200 or 800.373.1327

(4) What is the Plan ID number and the Plan Year?

The Plan's taxpayer identification number is **42-1480598.** The Plan Year for purposes of offering benefits is a 12-month period, which begins January 1 and ends December 31.

(5) Why was the 125 Flexible Benefit Plan Established?

The Employer has established an IRC Section 125 Flexible Benefits Plan (the "Plan") for its eligible employees, and permits you to select those benefits offered under the plan that will best fit your individual needs. Your Employer recognizes that not everyone's needs are the same, and that your needs may change over a period of time.

(6) What benefits are covered by the Plan?

As a participant in the Plan, you will have the right to choose among a number of benefit options that have been selected by your Employer ("the benefits"). Your employer determines which benefits will be offered under the Plan each Plan Year. Benefits may be nontaxable or taxable to you. There will be full withholding of state and federal taxes from your wages for the taxable benefits chosen. Benefits options under this Plan are shown in Addendum 1. You must meet certain qualifications and requirements for coverage under some of the individual benefits offered by the Plan. Information regarding the available benefits under the plan will be distributed to you.

(7) If it becomes necessary to serve the Plan with any legal papers, upon who are they served?

The entity responsible for receiving any legal papers for the Plan is the Plan Administrator, which is your Employer. Such service should be addressed to: Radiology Consultants of Iowa, 1948 First Avenue NE, Cedar Rapids, IA 52402.

PARTICIPATION & ELIGIBILITY

(8) Who is a participant?

Employees who actually elect benefits in the Plan are called "Participants." In most circumstances you must be eligible to participate in the Plan and enroll in the Plan before you may become a participant. Once a Participant, you may receive those benefits selected by you. Your spouse and dependents may receive benefits under the Plan; however, they are not considered participants under the Plan since they are not employees. A dependent may receive benefits under the Plan if they meet the definition of dependent for the specific benefit as defined by the IRS Code. A spouse may receive benefits under the Plan if they meet the definition of dependent for the specific benefit as defined by the IRS Code.

(9) What are the Plan's eligibility requirements?

You are eligible to participate under the Plan on the first payroll payment date following your date of employment. All active employees regularly working 15 hours per week are eligible to participate.

Eligibility for the Premium Payment Insurance Benefits listed in the Addendum is also subject to the additional eligibility requirements, if any, specified in their Insurance Plan. Eligibility for HSA Benefits also requires that you be an HSA-Eligible Individual.

In no event shall an employee or eligible dependent of an employee be permitted to participate in this Plan if the fact of such participation will result in the employee or eligible dependent being treated as not an eligible individual for purposes of making contributions to a health savings account (HSA), provided the employee or eligible dependent has established or is planning to establish a HSA. As an employee, you shall be required to affirmatively state on the Plan's election form that you or your eligible dependents' participation in this Plan will not cause the parties' ineligibility for the HSA.

(10) How do I become a Participant?

Once you meet the eligibility requirements described in Q&A 9, you become a Participant by completing an Election Form/Salary Reduction Agreement, on which you elect one or more of the benefits available under the Plan and agree to a salary reduction to pay for those benefits selected. Your Employer will provide you with instructions on completing this process. The Election Form/Change of Coverage Form will be provided to you during the Annual Re-Enrollment Period, and, at that time, you will be given the opportunity to elect to change your benefits for the next Plan Year.

(11) When do I become a Participant?

You become a Participant on the first entry date of the Plan Year after you are eligible to participate and have completed the eligibility requirements stated above. You continue to participate in the Plan until (a) you sign an enrollment form to cancel your election for the

following year during the annual re-enrollment period; (b) the Plan is terminated by your Employer; (c) the date on which you cease to be an eligible employee (because of retirement, termination of employment, layoff, reduction in hours, or for any other reason), except that eligibility may continue beyond such date for purposes of COBRA coverage (see Q&A 14 below), or as may be permitted by the Plan Administrator on a uniform and consistent basis (but not beyond the current Plan Year)); or (d) in limited circumstances, you revoke your election.

(12) After becoming a Participant, when do I become ineligible to continue in the Plan?

Participation in the Plan ceases upon death, termination of employment, failure to meet eligibility requirements, termination of the Plan, retirement, filing of a false or fraudulent claim for benefits or failure to pay contributions required during any period in which you are on a leave of absence. If you are rehired within the same Plan Year and are eligible for the Plan, 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, your prior elections will be reinstated.

The Premium Payment Insurance Benefits listed in the Addendum will terminate as of the date(s) specified in those Insurance Plans. See Question (14) for COBRA options.

(13) Can I change my election for benefits during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the reduction amounts you have selected during the Plan Year (known as the irrevocability rule) unless you terminate your employment with the Employer. There are several exceptions to the irrevocability rules referred to as *Change in Election Events*. Change in Election events do not apply to all benefits. The changes must be on account of and consistent with the event. If you have a qualifying Change in Election Event (including Change in Status), you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days of the occurrence. "Change in Election Events" include the following:

- FMLA (Family Medical Leave Act) (see Q&A 16).
- Change in marital status (such as marriage, death of a spouse, divorce).
- Change in number of dependents (such as a birth of a child, adoption or placement for adoption, or death of a dependent).
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement (such as a specific age, full-time student status, dependent marries).
- A change in you, your Spouse's or your Dependent's place of residence that affects your eligibility in the network service area.

Any of the following events that change the employment status of you, your spouse, or your dependent and that affects benefit eligibility under this or any other plan of your spouse or dependent:

- Termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in worksite
- Switching from salaried to hourly, full time to part time (or vice versa); incurring a reduction or increase in hours or any other similar change which; makes the individual become (or cease to be) eligible for a particular benefit.
- Gains in coverage eligibility under another employer's plan.
- Certain judgments, decrees and orders.
- Medicare or Medicaid.

- Change in cost such as a significant change in premium.
- Change in coverage such as significant curtailment of coverage, addition or significant improvement of plan option, loss of other group coverage, change in election under another employer plan, or DCAP coverage changes.
- Effective April 1, 2009 - Change in eligibility for Medicaid or SCHIP coverage, such as termination of eligibility or newly eligible for premium assistance (You must inform the Plan Administrator and complete a new agreement within 60 days of this occurrence.)

You may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (that is not a health FSA) if the following conditions are met:

- You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result you ceasing to be eligible for coverage under the Plan; and

- You represent that the revocation of the election of coverage under the Plan corresponds to your intended enrollment, and the intended enrollment of any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

You may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (that is not a health FSA) if the following conditions are met:

- You and your dependents are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

You represent that the revocation of the election of coverage under the group health plan corresponds to your intended enrollment, and the intended enrollment of any related individuals who cease coverage due to the revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

If your employer offers you the ability to make contributions to your health savings account (HSA) through the Plan, then you may be permitted to change your contribution amount, provided the change is applied only to amounts contributed after the date the change is made.

(14) What is COBRA?

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA Continuation Coverage will be available to you only if you have a positive Health Care Expense balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

COBRA Notifications. If you lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

Cost of COBRA Coverage. You pay the full cost to continue participation in the Health Care Flexible Spending Account, plus an administrative fee of two percent, or 102 percent of the amount you authorized to contribute to the Health Care Flexible Spending Account.

COBRA Continuation Coverage Payments. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full payment is received. Each month's premium is due prior to the first day of the month of coverage. You are responsible for making timely payments.

If you fail to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

(15) How will participating in the Plan affect my Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security 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 Plan participation often offsets any reduction in other benefits.

(16) What is the "Family Medical Leave Act" and how does it affect my benefits

If your Employer is subject to the Family Leave Act of 1993 (FMLA) and if you are eligible to have a leave of absence under FMLA, then you may continue to pay for your plan benefits, such as Medical and Dental Insurance Plan coverage and your Health FSA Benefits, on an after-tax basis, or, if offered by the Employer, and through other arrangements (such as pre-paying on a pre-tax basis through extra salary reductions before you go or after your leave). If your Employer pays a portion of your health insurance coverage, then it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the health insurance premiums. If applicable, a complete explanation of your FMLA rights and responsibilities will be furnished to you separately.

(17) How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly. Your Employer may amend any provisions of any benefit supplements to the Plan, merge or combine benefit supplements, and add or delete benefit supplements. Any such Plan amendment shall be effective for periods after the later of the adoption date or the effective date of the amendment, unless otherwise required by law. If such amendment adds a new benefit to the Plan, only those expenses incurred after the amendment date may be eligible for reimbursement under the Plan.

(18) What are "Premium Payment Benefits" and how are they paid?

Under the Plan you may be able to elect benefits such as Medical insurance, Dental insurance, Vision Insurance, Group Term Life insurance, Long Term Disability insurance, Cancer insurance, Flexible Un-Reimbursed Medical, Dependent Child Care and Accidental Death and Dismemberment (AD&D) (to see what benefits are offered under this Plan, refer to Addendum 1). We call these insurance benefits "Premium Payment Benefits." You receive your insurance coverage through these separate plans, and not through this Plan. However, the premiums you owe to participate in these plans are paid with the pre-tax salary reductions elected by you. Some of these benefits may be taxable to you. If you elect Group Term Life insurance benefits in excess of the amount that qualifies for non-taxable treatment under the IRS Code, the excess value of such benefits will be treated as taxable income. If you elect Long Term Disability insurance benefits, the value of LTD benefits received by you due to a disability claim will be treated as taxable income. In some cases, you may be able to pay your COBRA premiums through the Plan.

(19) What are "Health FSA Benefits"?

If you elect Health FSA (**F**lexible **S**pending **A**ccount) Benefits, you will be reimbursed by the Plan for your eligible Medical Care Expenses on a pre-tax basis. On the Election Form/Salary Reduction Agreement, you can allocate the amount of dollars you would like set aside in this account.

Health FSA Benefits are intended to pay benefits for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and shall not be taken into

account when determining benefits payable under any other plan. In addition, there are certain restrictions on the type of FSA benefits for which you may qualify if you or your spouse participates in a Health Savings Account. Please refer to Addendum 1 to determine the type of FSA account offered under this Plan.

The FSA account is set up in your name in order to keep a record of the reductions made to your salary to provide for the benefit under the FSA and the reimbursements made to you from the Plan. Your FSA Account is a record-keeping account and is not funded (all reimbursements to you are paid from the general assets of the Employer), nor does it bear interest. For example, if you have elected $2,400 to be reimbursed for the Plan Year for Medical Expenses under a Health FSA then your account will be credited with $2,400 for the year. In this example, you will have $100 deducted from each of the 24 pay periods for that year and credited to your account.

(20) What is the Maximum Health FSA Benefit that I may elect?

During a Plan Year, the maximum amount a Participant may contribute to the Un-Reimbursed Medical Expense Reimbursement Account is $3,050 or the maximum contribution as determined by the Internal Revenue Service (IRS) for the current and subsequent years.

(21) What amounts will be available for Health FSA reimbursement during the Plan Year?

Plan Participants are entitled to the full amount of the coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) for Medical Expenses incurred during the Plan Year, regardless of the amount of contributions credited to your account.

(22) What are "Medical Care Expenses"?

They are expenses incurred by you, your spouse or eligible dependents for medical care as defined in the IRS Code 213. Generally, these expenses are for those items that are medically necessary and are not reimbursable from any other source, including insurance coverage. They can be medical, dental, vision, prescription, or most over-the-counter (OTC) expenses. Medical expenses must be for the treatment and/or prevention of a physical or mental defect or illness. Over-the-counter (OTC) products sold lawfully without a prescription at a reasonable quantity can be reimbursed with pre-tax dollars. OTC products that serve a purpose in addition to a medical purpose, such as personal/cosmetic and/or general health, can only be reimbursed if your health care provider states you have a medical need. Expenses that are merely beneficial to the general health do not qualify for reimbursement such as vitamins and supplements. Under the CARES Act, menstrual care products are an eligible expense as of January 1, 2020. Menstrual care products are defined as tampons, pads, liners, cups, sponges, or similar products used by an individual with respect to menstruation. Consult your Plan Administrator with any questions about the eligibility of expenses.

(23) When are Medical Expenses Incurred?

For medical expenses to be reimbursed, they must have been incurred during the current Plan Year or grace period (if applicable). Medical expenses are treated as having been *incurred* when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care.

(24) What must I do to be reimbursed for Medical Care Expenses?

If you elect Health FSA Benefits, then you will have to take certain steps to be reimbursed for your expenses. When you incur an expense that is eligible for payment, you must submit a

claim to the Administrator on a Medical Request Reimbursement Form that will be supplied to you. You must attach written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred. You will receive reimbursement for no more than the annual election you have made for the plan year. Any unused Flexible Spending Account funds from the previous plan year up to 20% of the groups maximum contribution amount may be carried forward to be used in the following plan year. Participants who do not enroll in the flexible spending account the following year may carryover a minimum of $50. Carry forward amounts from the previous plan year may reduce your amount available to pay previous plan year expense during the run-out period, will be counted against the permitted carryover amount, and cannot exceed the carryover amount. You will have 90 days after the Plan Year ends to submit claims for expenses incurred. You will be notified in writing if any claim has been denied and the reason for the denial.

Your Employer may elect to provide you with a debit card that can be used to pay for or reimburse you for medical expenses as part of the Plan's Flexible Un-Reimbursed Medical Expense Plan. A participant's use of the debit card shall follow all of the requirements governing debit card use including, but not limited to, applicable Treasury regulations. Prior to using a debit card, you will be required to agree in writing to the rules governing its use. Any improper payment of a benefit using the debit card will require you to repay the amount of the improper payment to the Plan and will suspend your use of the debit card.

(25) What if I have a balance in my FSA Account after termination of participation?

When a participant ceases to be a participant, the participant's salary reductions and election to participate will terminate. He/She will not be able to receive reimbursements for Medical Care Expenses incurred after the date the participant's employment terminate or he/she ceases to be eligible to participate in the Plan. The participant will have 90 days from the date that he/she is no longer eligible to submit claims for reimbursement of expenses incurred prior to the date in ineligibility.

(26) What are "DCAP" Benefits?

If you elect DCAP (**D**ependent **C**are **A**ssistance **P**lan) Benefits, you will be reimbursed for your eligible Dependent Care Expenses on a pre-tax basis. On the Election Form/Salary Reduction Agreement, you can allocate the amount of dollars you would like set aside in this account. In addition, a DCAP Account will be set up in your name to keep a record of the reimbursements made to you and the balance for which you are entitled. Your DCAP account is merely a record-keeping account and is not funded (all reimbursements are paid from the general assets of the Employer).

(27) What is the amount of DCAP Benefits that I may elect?

The amount of Dependent Care Expenses reimbursement that you choose cannot exceed the maximum amount specified in the IRS Code 129. The maximum amount is currently $7,500 for a calendar year if you are:

- married and file a joint return;
- married, but you furnish more than one-half the cost of maintaining the dependents for whom you are eligible to receive tax-free reimbursements under the DCAP, your spouse maintains a separate residence for the last six months of the calendar year, and you file a separate tax return;

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

If you are married and reside with your Spouse, but you file a separate federal income tax return, then the maximum DCAP Benefits that you may elect is $3,750 for a calendar year. This amount represents the amount you may elect under this Plan and any plan of your spouse.

(28) How are my DCAP Benefits paid?

When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the costs will be paid through pre-tax salary reductions or after-tax deductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck.

(29) 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 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. For example, if you have an annual election of $3,000.00 and have a total of child care expenses of $750.00 by March 20th, you will be reimbursed $625.00, which will be the total of 5 contributions made through payroll at $125.00 per pay period. You may be eligible for reimbursement of expenses once you terminate from employment, provided your DCAP Account has a remaining balance and the expenses are incurred in the Plan Year.

(30) What are "Dependent Care Expenses"?

Dependent Care Expenses are employment-related expenses incurred on behalf of any eligible dependent that meets the requirements as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses eligible for reimbursement:

a) Each Dependent for whom you incur the expenses must be a Qualifying Individual as defined below.

- Under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
- Your spouse or a person who is your dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.

b) The reimbursement (when aggregated with all other DCAP reimbursements during the Plan Year) may not exceed the least of the following limits:

- The year-to-date amount that has been withheld from your compensation for reimbursement for Dependent Care Expenses for the period of coverage, less any prior reimbursements for Dependent Care Expenses during the period of coverage.
- The amount of DCAP Benefits that you elect may not exceed the statutory maximum ($7,500 or $3,750 for the calendar year, depending on your marital and tax filing status).

- Your earned income for the calendar year (after your Salary Reduction under the Plan).
- If you are married, your Spouse's actual or deemed earned income for the calendar year. Your Spouse will be deemed to have earned income of $250.00 ($500.00 if you have two or more Qualifying Individuals), for each month in which your Spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student.

c) The expenses are incurred to enable you (and your Spouse if you are married) to be gainfully employed, which means working or looking for work. There is an exception: if your Spouse is not working or looking for work he must be a full-time student or physically or mentally incapable of self-care.
d) 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.
e) You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.
f) If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your Dependent under federal tax law; or (2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.
g) If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
h) The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under IRS Code 151. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
i) The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

Please consult the Plan Administrator if you have any doubts about which expenses are eligible.

(31) When must the Dependent Care Expenses be incurred?

Dependent Care Expenses must have been incurred during the Plan Year. A Dependent Care Expense is *incurred* when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. You cannot request reimbursement for dates of care that have not yet been rendered as in paying for day care on the first of the month for care given during the entire month, the expense has not been incurred until the end of that month. You may not be reimbursed for expenses arising before the Plan became effective, 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. **The total dependent care costs paid by the participant and attributable to dependent care rendered during the plan year must not extend beyond the close of plan year regardless of whether such costs have been paid by the participant.**

(32) What must I do to get reimbursed for my Dependent Care Expenses?

If you elect DCAP Benefits, then you will have to take certain steps to be reimbursed for your expenses. When you incur an expense that is eligible for payment, you must submit a claim to

the Administrator on a Dependent Care Request Reimbursement Form. You must either attach documentation for the expense from the provider, or have your day care provider sign the form to certify the expense. You must also provide the person's Social Security number or taxpayer ID number. Your reimbursement will not exceed the credits currently available in the account. The participant will have 90 days after the end of the Plan Year to submit expenses. All unused dollars after the 90 days will be forfeited under the "Use-or-Lose" IRS rule. You will be notified in writing if any claim has been denied and the reason for the denial.

(33) What if I have a balance in my DCAP Account after termination of participation?

When a participant ceases to be a participant, the participant's salary reductions and election to participate will terminate. He/She will not be able to receive reimbursements for Dependent Care Expenses incurred after the date the participant's employment terminate or he/she ceases to be eligible to participate in the Plan. The participant will have 90 days from the date that he/she is no longer eligible to submit claims for reimbursement of expenses incurred prior to the date in ineligibility.

(34) Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits.

(35) If I elect DCAP Benefits, can I still claim the Dependent Care Credit on my federal tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the *balance* of your Dependent Care Expenses may be eligible for the household and dependent care service tax credit under IRS Code 21 (Dependent Care Credit) (i.e., if you elect $3,000.00 of coverage under the DCAP and are reimbursed $3,000.00, but you had Dependent Care Expenses totaling $5,000.00, you could count the excess $2,000.00 when calculating the Dependent Care Credit). Please note that any DCAP Benefits received under the Plan will offset the amount of any Dependent Care Credit you may have available.

(36) What if I have a claim that is denied by the Plan?

The Plan Administrator will notify you of the specific basis for an adverse benefit determination. The notice will contain the following information:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A statement that the Plan will provide to you upon request any information the Plan has generated or obtained in the process of ensuring and verifying that, in making the particular determination, the Plan complied with its own administrative processes and safeguards that ensure and verify appropriately consistent decision-making in accordance with the Plan's terms.
- Any specific rule, guideline, protocol or other similar criterion that was relied upon in making the denial decision.
- A statement of the Plan's review procedure and time limits for review, including the right to bring a civil lawsuit under ERISA Section 502 (a) following a review.
- A description of any additional material or information, if any, necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary.

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

When you receive an adverse benefit determination, you may appeal the decision. An appeal must be submitted to the Plan Administrator, in writing, no later than 180 days following your receipt of the notification. You may submit to the Plan Administrator written comments, documents, records, and other information to support your appeal of the Claim. You may request that you be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

If you appeal, the Plan Administrator will review your claim and any additional information you furnish. The review will take into account all relevant information submitted by the claimant, whether or not presented or available at the time of the initial Claim determination.

Normally, the Plan Administrator will decide your appeal within 60 days after it is received. If special circumstances exist with your appeal, the Plan administrator may extend the time period for consideration of your appeal for up to an additional 60 days. If this occurs, the Plan Administrator will send you a notice of the extension, indicating the special circumstances requiring the extension, and the date by which the review will be concluded. After your appeal is decided, the Plan Administrator will inform you in writing of its final decision. The decision will contain the Plan provisions upon which the decision was based and instructions for requesting information on which the Plan Administrator based its decision.

You may authorize one person to represent you regarding communication with the Plan Administrator for specific claims or an appeal. If you decide to have another person represent you it must be done at your expense. You may name only one person as your authorized representative at a time. You may revoke an authorized representative designation at any time.

(37) What are my ERISA Rights?

The Flexible Benefits Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Benefit option is governed by ERISA.

Your Rights under ERISA. As a participant in the 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 will be entitled to the following.

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 collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) 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), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or 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 summary plan description and the document governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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 you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example,

if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

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 the Division of Technical Assistance and Inquires, 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 Employee Benefits Security Administration at 1-866-444-3272.

(38) NMHPA (Newborns' and Mother's Health Protection Act of 1996).

Group health plans and health insurance issuers generally, may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(39) HEART (The Heroes Earnings Assistance and Relief Tax Act of 2008)

Cafeteria Plans are amended to allow health FSAs to provide for qualified reservist distributions of all or a portion of the health FSA account balances of participants who are reservists called to active duty for 180 days or more (or for an indefinite period). Distributions may be made at any time from the date of the call to duty through the last date on which reimbursements may be made for the plan year in which the call occurred.

(40) HIPAA Plan Document Amendment

Health Insurance Portability and Accountability Act (HIPAA). Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provision" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans, including Health Care Flexible Spending Accounts. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual.

Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- Enrollment of eligible individuals;
- Eligibility determinations;
- Payment for coverage;
- Claim payment activities;
- Coordination of benefits; and
- Claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provision to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

ADDENDUM 1

Benefits checked are available to eligible Participants in the Section 125 Flexible Benefits Plan

x	**Medical Plan Premiums**
x	**Dental Plan Premiums**
x	**Vision Plan Premiums**
	Group Term Life Plan Premiums (Employees Only)
	Long Term Disability Income Plan Premiums
	Short Term Disability Income Plan Premiums
	Cancer Insurance Premiums
x	**Dependent Child Care Reimbursement Plan ($7,500)**
x	Debit Card Option
x	**General Purpose Flexible Un-Reimbursed Medical Expense Plan ($3,400)**
x	Debit Card Option
x	Carryover of 20% of maximum contribution to following plan year
x	**Limited Purpose Flexible Un-Reimbursed Medical Expense Plan ($3,400)**
x	Debit Card Option
x	Carryover of 20% of maximum contribution to following plan year
x	**AFLAC Insurance Premiums**
x	**HSA contributions**
x	**Individual Insurance Coverage**