



CITY OF ALBANY

SUMMARY PLAN DESCRIPTION

Flexible Spending Account

Effective: 7/1/2013

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CITY OF ALBANY
SUMMARY PLAN DESCRIPTION
FLEXIBLE SPENDING ACCOUNT

I. Introduction

This Summary Plan Description provides, in general terms, the main features of the CITY OF ALBANY Flexible Spending Account Plan (the "Plan") and the related Group Sponsored Insurance Plan, Health Related Expense Plan and Dependent Care Assistance Plan, how it can work for you, and how it can benefit you.

Under the Plan, you may choose to redirect a portion of your wages to pay for certain benefits for you, your spouse, and your dependents with pre-tax dollars instead of after-tax dollars. Participating in the Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

You should read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a Participant. You should direct any questions you have to the Employer. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. **IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL TAKE PRECEDENCE.**

The provisions of the Plan, as initially adopted or subsequently amended and restated, as the case may be, are effective 7/1/2013, through 6/30/2014. Your Plan's records are maintained on a fiscal period known as the Plan Year.

This Summary Plan Description does not describe the Group Sponsored Insurance Plan. Consult the Group Sponsored Insurance Plan Document and the separate Summary Plan Description for the Group Sponsored Insurance Plan.

II. Your Plan at a Glance

PERIOD OF COVERAGE and **PLAN YEAR** of this Plan: 7/1/2013 through 6/30/2014

Cafeteria Plan Name: CITY OF ALBANY

Three Digit Plan Number: 501

Employer Information: CITY OF ALBANY
333 BROADALBIN ST SW
PO BOX 490
ALBANY, OR 97321
(541) 917-7512

Type of Legal Entity: Municipality

Benefits Coordinator: Human Resources/Benefits Representative

Legal Representative: CITY OF ALBANY

Plan Administrator: CITY OF ALBANY

Third Party Administrator: PacificSource Administrators, Inc.
PO Box 70168
Springfield, OR 97475
Phone: (800) 422-7038
FAX: (866) 446-6090

Secure Web Portal (TPA): <https://hrbenefitsdirect.com/PSA>

Claim Mailing Address (TPA): PacificSource Administrators, Inc.
P.O. Box 2797,
Portland, OR 97208

**Employer Representative or
Named Fiduciary:** CITY OF ALBANY

The HIPAA Effective date: 7/1/2013

HIPAA Privacy Officer: CITY OF ALBANY

BENEFIT PLANS: The administrative plan expenses are paid by the Employer. The following Plans are offered under the Flexible Spending Account. You may elect:

- **Group Sponsored Insurance Plan (EDP):** your salary reductions will be used to pay the premium for medical and hospitalization insurance, major medical insurance, dental insurance, and/or insurance for you and your eligible family members.
- **Health Related Expense Plan (HRE):** your salary reductions will be deposited into an account from which funds will be withdrawn to reimburse you for eligible healthcare expenses incurred by you and your eligible family members.
 - **Maximum Salary Reduction:** \$2,500
 - **Minimum Salary Reduction:** \$0
 - **Maximum Annual Reimbursement Limit:** \$2,500
 - **Allows all applicable Change in Status options:** Both Increases and Decreases
 - **Reimbursements of HRE expenses include timeframe:** During the period of coverage, defined under participation rules, if such expenses are otherwise eligible healthcare expenses under the Code.
 - **Debit Card Availability:** No
- **Dependent Care Assistance Plan (DCE):** your salary reductions will be deposited into an account from which funds will be withdrawn to reimburse you for eligible dependent care expenses.
 - **Maximum Salary Reduction:** \$5,000 per year (legal maximum of \$5,000; \$2,500 for a married individual filing a separate return.)
 - **Minimum Salary Reduction:** \$0
 - **Allows all applicable Change in Status options:** All of the events constituting a change in status under the regulations shall be allowed.
 - **Reimbursements of DCE expenses include timeframe:** During the period of coverage and/or following termination - that is, through the remainder of the Plan Year if such expenses are otherwise eligible expenses under the Code.

Eligibility Requirements:

- No requirements defined

Entry Dates:

- First of the month following date of hire

Exclusions:

- None

Deemed Elections: Under the Group Sponsored Insurance Plan you will be deemed to elect for each upcoming Plan Year whatever election is in effect in the current Plan Year, unless you expressly change your election by turning in a completed election form prescribed by the Employer.

For example, if you are enrolled in the Group Sponsored Insurance Plan in the current year and want to remain enrolled in the upcoming year, you need not do anything, but if you want to stop participating in that Plan, you must affirmatively elect not to participate during the open

enrollment period for the upcoming Plan Year. Under all the other Plans, you must make an affirmative election to participate every year by turning in a completed election form prescribed by the Employer or you will be deemed to have elected not to participate.

Election Changes: The election changes allowed under the Plan are those made effective by the IRS January 1, 2001. Any new election must be made and communicated in writing to the Employer within **30 days** of the change in status.

Forfeitures:

- Unclaimed cash balances are forfeited to the Employer after the end of a Plan Year.
- All forfeitures shall be used to offset losses and administration of the Plan.
- Cash balances forfeited to the Employer cannot be returned directly to the individual Participant(s) who forfeited those funds.

Claim Reimbursement Forms may be submitted the following ways:

- Electronically via our secure web portal: <https://hrbenefitsdirect.com/PSA>
- Faxed to (866) 446-6090
- Mailed to PO Box 2797, Portland, OR 97208

Claim Submission Period Ends: 90 days after the close of the Plans period of coverage

Grace Period:

- Your Employer does not offer a Grace Period on the FSA plan(s).

Documentation needed for claim submission:

- Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense and the amount of your expense. Note: In some instances, a statement from the provider that a health expense is medically necessary may be required.

Participation Rules:

- If you terminate employment, your FSA participation ends on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
- If you experience a loss of eligibility, your FSA participation ends on the date loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

Treatment of Rehires:

- If you terminate and are rehired within 1 month of the date of termination you will immediately rejoin the plan and be reinstated with the same elections as before termination of participation.
- If you terminate employment and are rehired 1 month or more after the date of termination you will be treated as a new hire and must re-satisfy Plan eligibility requirements to rejoin the plan.

Treatment of Participants that regain eligibility:

- If you experience a loss of eligibility and then later regain eligibility within 1 month of the loss of eligibility date you must re-satisfy Plan eligibility requirements to rejoin the Plan.
- If you experience a loss of eligibility and then later regain eligibility 1 month or more after

the loss of eligibility date you will be treated as a new hire and must re-satisfy the Plan eligibility requirements to rejoin the plan.

Continuing Plan Participation under FMLA: Per Federal Law, coverage may continue under the provisions of Family Medical Leave Act (FMLA). If applicable, the option for member payment of continuation is listed below:

- FMLA coverage is offered and paid by the Employee based on the following: Pre-pay with after tax dollars, Pre-pay with pre-tax dollars, Pay-as-you-go method, or Catch-up method

COBRA continuation coverage: Per Federal Law, COBRA continuation coverage may be offered. **Note:** *COBRA coverage is not required for calendar years in which the Employer has 20 or fewer Employees.*

Federal law requires some Employers sponsoring a Group Sponsored Insurance Plan to offer Employees and their covered dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

III. Participation in the Plan

Who is eligible to participate?

Employees who actually participate in the Plan are called "Participants". You are eligible to participate if you have met the required eligibility standards and waiting period as indicated below:

- No requirements defined

Eligibility for the Group Sponsored Insurance Plan is also subject to the additional eligibility requirements, if any, specified in the medical insurance plan.

An "**Employee**" is an individual that the Employer classifies as a common-law Employee and who receives Compensation from the Employer.

When can I enroll in the Plan?

Your "entry date" is the date on which you become eligible to participate in the Plan as indicated below:

- First of the month following date of hire

Are there any Employees who are not eligible to participate in the Plan?

The following Employees are excluded from participating in the Plan:

- None

What must I do to enroll?

You will be given notice of your eligibility to participate prior to your entry date so that you have time to decide whether or not to participate and to make your elections. To become a Participant you must complete and sign an enrollment form and salary reduction agreement prior to your entry date.

How do I renew my election?

After the initial period of coverage, you may renew your participation for the next Plan Year by filing your elections with your Employer or the designated representative during the next open enrollment period. Failure to make new elections during open enrollment will be treated as an election not to participate in the Plan.

When does participation end?

The date your participation will cease under the different Plans offered under the Plan varies from Plan to Plan. Under the various Plans described in the Benefit Option Section, your participation in each Plan will, unless otherwise expressly stated, cease on the date you terminate employment or otherwise cease to be eligible under the Plan; provided that you will continue to be covered under any insurance contract through the end of any period for which premiums have already been paid as of the date you terminate employment or otherwise cease to be an eligible Employee.

- Upon termination, FSA participation ends on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
- Upon loss of eligibility, FSA participation ends on the date loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

What if I terminate and I am rehired?

If a Participant terminates his or her employment and then is rehired within 1 month of the termination date the Employee will immediately rejoin the plan and be reinstated with the same elections as before termination of participation.

If a Participant terminates his or her employment and is rehired 1 month or more after the termination date the Employee will be treated as a new hire and must re-satisfy Plan eligibility requirements to rejoin the plan.

What if I lose eligibility and then later regain eligibility during the Plan Year?

If a Participant regains eligibility within 1 month of the loss of eligibility date then they must re-satisfy Plan eligibility requirements to rejoin the Plan.

If a Participant experiences a loss of eligibility and regains eligibility 1 month or more after the loss of eligibility date then they will be treated as a new hire and must re-satisfy the Plan eligibility requirements to rejoin the plan.

IV. Benefit Options

Group Sponsored Insurance Plan

What is the “Group Sponsored Insurance Plan”?

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

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

If a Health Savings Account (HSA) is offered by your Employer and you elect to participate, eligible Participants may make contributions to the HSA on a pre-tax basis from which funds can be withdrawn to pay for eligible healthcare expenses.

Health Related Expense Plan

What is the “Health Related Expense Plan”?

If the Health Related Expense Plan (HRE Plan) is elected by the Employer for inclusion in the Plan, you may use the HRE Plan to pay for eligible healthcare expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary.

What is my “HRE” account?

If you elect to participate in the HRE Plan, the Employer will establish an account called Health Related Expenses (HRE) in your name to keep record of the reimbursements that you are entitled to, as well as the money that you elected to have reduced from your salary or wages. The HRE account is a recordkeeping account and does not bear interest.

What are the benefits that I may elect under the HRE Plan?

The maximum salary reduction you can elect under this Plan is \$2,500 with a minimum salary reduction of \$0.

How are my benefits paid for under the HRE Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer).

What health related expenses may be reimbursed?

Eligible healthcare expenses are generally defined in Section 213(d) of the Internal Revenue Code and a partial list of eligible healthcare expenses has been made available to you. The HRE Plan cannot reimburse you for any expenses that have been reimbursed by any other plan

or source, for any insurance premiums, for cosmetic surgery, or for any other healthcare expenses not eligible to be provided through a HRE Plan. In addition, you cannot claim a tax deduction for any expenses reimbursed under the HRE Plan.

What amounts will be available from the HRE account at any particular time during the Plan Year?

Subject to this HRE Plan's maximum allowable election the full amount you have elected for the Plan Year (reduced by prior reimbursements made during the same Plan Year) will be available to you for eligible healthcare expenses regardless of the amount that you have contributed when you submit a claim. This is known as the "uniform coverage" rule.

Is there any risk of losing or forfeiting the amounts that I elect?

You should be aware that the HRE Plan is subject to the "use it or lose it" rule discussed further below. You should read the Plan in its entirety before electing to participate in it.

If I terminate employment, when does my participation end?

Your participation in the HRE Plan will end on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

If I lose eligibility, when does my participation end?

Your participation in the HRE Plan will end on the date loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

Can I continue my HRE coverage after terminating employment?

Yes. As indicated on your enrollment form, the remaining monthly premiums will be taken from your final paycheck. In the alternative, if you wish to reimburse your employer (on a monthly basis) with after tax dollars, you must notify your employer in writing. You have until the end of the plan year to incur qualified health related expenses.

Note: This Summary Plan Description does not describe the Group Sponsored Insurance Plan. Consult the Group Sponsored Insurance Plan Documents and the separate Summary Plan Description for the Group Sponsored Insurance Plan.

Your Employer or PacificSource Administrators can provide you with more information about which expenses are eligible for reimbursement.

Dependent Care Assistance Plan

What is the "Dependent Care Assistance Plan"?

If the Dependent Care Assistance Plan (DCE Plan) is elected by the Employer for inclusion in the Plan, you may use the DCE Plan to pay for eligible dependent care expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary. Examples of types of eligible dependent expenses might include: infant care, daycare, elder care etc. You may receive reimbursements under this Plan only if the dependent care is necessary to enable you and your spouse to work or seek employment, or if you work and your spouse is a student or is disabled. The dependent must reside with you more than half the year for the expenses with respect to that dependent to be eligible for reimbursement under this portion of the DCE Plan.

What is my “DCE” account?

If you elect to participate in the DCE Plan, the Employer will establish an account called Dependent Care Expense (DCE) in your name to keep record of the reimbursements that you are entitled, as well as the money that you elected to have reduced from your salary or wages. The DCE Plan will then use the total amount credited to your account to reimburse you for your and your spouse or dependents’ eligible dependent care expenses. The DCE account is a recordkeeping account and does not bear interest.

What are the benefits that I may elect under the DCE Plan?

The maximum salary reduction allowed by the DCE Plan is an amount equal to you and/or your spouse’s earned income (as defined by the IRS). The maximum salary reduction you can elect under this Plan is \$5,000 with a minimum salary reduction of \$0. In the case of a married individual filing a separate income tax return, the election cannot exceed \$2,500 (Code Section 129). You must commit to a salary reduction to pay the annual DCE contribution equal to the coverage level that you have chosen.

How are my benefits paid for under the DCE Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCE benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer).

What amounts will be available from the DCE account at any particular time during the Plan Year?

Reimbursement of dependent care expenses will be made from your DCE account. Reimbursements may not exceed the balance in your DCE account at the time that your claim is received or paid.

Is there any risk of losing or forfeiting the amounts that I elect for Dependent Care Expense benefits?

You should be aware that the DCE Plan is subject to the “use it or lose it” rule discussed further below. You should read the Plan in its entirety before electing to participate in the Plan.

Can I Continue DCE coverage After Terminating Employment?

When you cease to be a Participant under the DCE benefit, your salary reductions and election to participate will terminate also. However, the Participant will be able to receive reimbursements for DCE Expenses incurred during the period of coverage following termination through the end of the Plan Year.

What DCE Expenses may be reimbursed?

DCE means employment-related expenses incurred on behalf of a person who meets the requirements to be a qualifying individual, as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as DCE that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a qualifying individual, that is, he or she must be:
 - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or

- stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
- your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
 - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

NOTE: Under a special rule for children of divorced or separated parents, a child is a qualifying individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Employer for more information on which individuals will qualify as your qualifying individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCE account.
- The expenses are incurred for services rendered after the date of your election to receive DCE Benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.
- The expenses are incurred for the care of a qualifying individual or for household services attributable in part to the care of a qualifying individual.
- If the expenses are incurred for services outside of your household for the care of a qualifying individual other than a person under age 13 who is your qualifying child, then the qualifying individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility 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.
- The person who provided care was not your spouse, a parent of your under-age-13 qualifying child, or a person for whom you (or your spouse) are entitled to a personal exemption under Code §151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the qualifying individual stays overnight.

V. Administrative Provisions

Funding and Type of Plan Administration

The amount reduced from your salary or wages cannot exceed the amount of your annual salary or wages. This is a contract administration plan. The Employer has designated PacificSource Administrators, Inc. ("PSA") to act as the Third Party Administrator. PSA processes claims for the Plan. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan. All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy.

Nothing herein will be construed to require the Employer or PSA to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

You must make all elections about the use of the Plan before your entry date into the Plan. Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Employer).

Only expenses incurred on or after your entry date and prior to the end of the Plans period of coverage are eligible for payment. Your period of coverage is generally the same as the Plans period of coverage but if you begin or end participation in the middle of the Plan Year, your period of coverage is the portion of the Plan Year during which you were a Participant in the Plan. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid. You may submit claims incurred during your "period of coverage" for 90 days after the Plans period of coverage. Claims submitted beyond this "run out" period are ineligible for reimbursement.

Who qualifies as a child dependent under the Plan?

You and individuals who qualify as your dependents may receive benefits under the Plan. An individual may qualify as your dependent for purposes of this Plan even if that individual is not your tax dependent. An individual who would qualify as your tax dependent but has gross income in excess of the exemption amount, is a dependent of a dependent, or is married and files a joint tax return with his or her spouse, will be considered your dependent for purposes of this Plan. This may include the Participant's children, grandchildren, stepchildren, parents, in-laws, or any other person (other than the Participant's spouse) whose principal place of abode is the home of the Participant and who is a member of the Participant's household. For purposes of the DCE Plan, a dependent must reside with you for more than half of the year for expenses with respect to that dependent to be eligible for reimbursement under that portion of

the Plan.

For purposes of the income exclusions under Code Sections 105(b) and 106, the term "child" includes adult children under the age of 27 that is the Employee's son, daughter, stepson, stepdaughter, legally adopted individual (or an individual placed with the Employee for adoption), and eligible foster child. Under Notice 2010-38, such a child does not have to satisfy the age limits, residency, support and other tests described in Section 152 of the Code in order to be considered an Employee's child for purposes of these new income exclusions.

Election Changes

If you wish to change your election based on a change in status, you must establish that the revocation is on account of and corresponds with the change in status. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a change in status. As a general rule, a desired election change will be found to be consistent with a change in status event if the event affects coverage eligibility.

Accounts subject to the uniform coverage rule (HRE) can be excluded. Specific to your Plan design benefits changes can/cannot be made as such below:

- Both Increases and Decreases EDP and DCE
- Both Increases and Decreases HRE

Can I change my elections under the Plan during the Plan Year?

As a general rule, your elections for the Plan Year are irrevocable for the balance of the year. Certain exceptions apply which may allow you to revoke your election and make a new election which is noted below.

- **A Change in Status** The Plan allows you to make a Mid-Plan Year change or revocation of a benefit election if the change or revocation is consistent with a change in status. In this regard, a change in status is any of the following:
 - An event that changes the Participant's legal marital status, including marriage, death of a spouse, legal separation, or annulment;
 - An event that changes the number of the Participant's dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent;
 - Any of the following events that change the employment status of the Participant or the Participant's spouse or dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in work site; and any change in employment status that causes the Participant, Participant's spouse or Participant's dependent to become (or cease to be) eligible under this Plan, any Employee benefit plan underlying this Plan, or any plan or Employee benefit plan of the Employer of the Participant's spouse or Participant's dependent (e.g., a change from hourly to salaried status where such change affects eligibility);
 - An event which causes a dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the applicable plan;
 - A change in the place of residence of the Participant or the Participant's spouse or dependent.

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

- **Significant Change in Cost or Coverage** If the cost of a plan underlying the Group Sponsored Insurance Plan increases (or decreases) during a Plan Year, then your elections will generally be automatically adjusted to reflect the increase (or decrease) in cost. The Plan allows the Employer, in the Employer's discretion, to offer you and other affected Participants new elections under certain limited circumstances due to a significant change in the cost or coverage of a plan underlying the Group Sponsored Insurance Plan. The Employer will notify you if and when such election changes become available. Under the DCE Plan, however, the following rules apply: (a) if the cost charged to you by your dependent care provider significantly increase or decreases during a Plan Year, then you may make a corresponding change in your dependent care election unless the cost of coverage is imposed by a dependent care provider who is a relative of yours; and (b) if you have an increased or decreased need for dependent care, or a change in dependent care providers, then you may make a corresponding change in your dependent care election. Thus, for example, if your child starts school, or moves to another daycare, you may change or revoke your dependent care election.
- **Changes Pursuant to Your HIPAA Enrollment Rights** The Plan allows you to make election changes pursuant to your enrollment rights under HIPAA, which are set forth in Section 9801(f) of the Internal Revenue Code. In brief, those rights provide that if you lose other healthcare plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, you may be able to change your healthcare plan elections and make a corresponding change to your elections under this Plan. If you would like to do so, you should contact the Employer as soon as possible after the event occurs, within 30 days of that event.

A Status Change Form is available from your Employer and is required to change your election during the middle of a Plan Year. If any change in Election Event occurs, you must inform the Employer and complete a new Change Form within 30 days after the occurrence. If the change involves a loss of your spouse's or dependent's eligibility for medical insurance benefits, then changes made to your Group Sponsored Insurance Plan will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

Other than the reasons above, when could my elections change?

During the Plan Year, however, there are several important exceptions to the irrevocability rule (the rule preventing changes to your annual election). Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Employer shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord

the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Employer may include withholding of any amounts due from your compensation.

Do limitations apply to those who are Highly Compensated and/or a Key Employee?

If you are a Highly Compensated Employee or a Key Employee as defined by the IRS, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Congress has intended this Plan to be available to all classes of Employees and not to be considered top-heavy in participation.

Plan experience will dictate whether contribution limitations on Highly Compensated or Key Employees will apply. Employees will be notified of these limitations if affected. Your Employer may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a Highly Compensated and/or Key Employee as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Are there any other events that allow me to change my decision to participate in the Plan that do not fit the events listed above?

IRS regulations allow Participants to make a mid-year election change for certain "Special Events" that are not specifically addressed in the Changes in Status categories. These events are:

- **Exception for COBRA Qualifying Events** If you, your spouse, or dependent gains or loses coverage due to a COBRA qualifying event, you may change your election under the Group Sponsored Insurance Plan and HRE Plan to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage.
- **Judgment, Decree or Order** If there is a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires a change in healthcare coverage for your child or foster child, you may make an election change to add or drop coverage as ordered under the Group Sponsored Insurance Plan and HRE Plan.
- **Entitlement to Medicare or Medicaid** If you, your spouse, or dependent becomes entitled to Medicare or Medicaid, you may make a prospective election change under the Group Sponsored Insurance Plan and HRE Plan to cancel or reduce healthcare coverage under the Employer's benefit plan. If you, your spouse, or dependent loses coverage to Medicare or Medicaid, you may make a prospective election to commence or increase coverage under the Employer's benefit plan.
- **HIPAA Special Enrollment Rights** If you gain the right to enroll in the Employer's Group Sponsored Insurance Plan or to add coverage for a family member under the special enrollment rights of HIPAA, the Participant may revoke an election for coverage during a period of coverage and make a new election under the Group Sponsored Insurance Plan and HRE Plan.
- **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Special Enrollment Rights** If you or your dependent lose health coverage as a result of loss of eligibility under Medicaid or a state child health plan, or if you become eligible for premium assistance from the state under its child health plan or Medicaid, you may request enrollment under the Group Sponsored Insurance Plan within 60 days after the loss of eligibility under Medicaid or the child health plan or after the date you are

determined to be eligible for premium assistance. This event does not apply to the Reimbursement Plan or to a high deductible healthcare plan.

- **Significant Curtailment of Coverage that is Not a Loss of Coverage** If your coverage under the Group Sponsored Insurance Plan and DCE Plan is significantly curtailed without a loss of coverage, you may revoke your election under the Plan that is being curtailed, but must make a new election for similar coverage under a new benefit package option.
- **Significant Curtailment of Coverage with a Loss of Coverage** If your coverage under the Group Sponsored Insurance Plan and DCE Plan is significantly curtailed with a loss of coverage, you may revoke coverage under the Plan being curtailed and make a new election for similar coverage under a new benefit package option, if available. You may drop coverage if no similar coverage is available. A cost change is an event only if a significant cost change is imposed by a non-relative provider in the case of the DCE Plan, and does not apply to the Reimbursement Plan.
- **Addition or Improvement of Benefit Package Option Providing Similar Coverage** If during a period of coverage under the Group Sponsored Insurance Plan and DCE Plan there is a new coverage option or a significantly improved option, you may be allowed to elect the new option or improved benefit option prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- **Coverage Change of Another Employer Plan** You may change your election under the Group Sponsored Insurance Plan and DCE Plan if the change is on account of and consistent with a change in another Employer's benefit plan and (i) the change is permitted under the Plan of the other Employer or (ii) the periods of coverage under your Plan are different from the periods of coverage under the plan of the other Employer.

Family and Medical Leave Act (if applicable)

What is the Impact of the Family and Medical Leave Act (FMLA)?

Notwithstanding any other provision in this Plan, the Employer may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more benefit coverage's under the Plan, (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement and (c) permit payment of the Participant's share of the cost of benefit coverage during an unpaid leave with after-tax dollars (or pay for benefits under another arrangement such as pre-paying the benefits with pre-tax dollars prior to the leave or "catching up" by paying for the benefits with pre-tax dollars subsequent to the leave) to the extent the Employer deems necessary or appropriate to assure the Plan's compliance with the provisions of the FMLA and any regulation pertaining thereto. You should consult the Employer if you have any questions.

How does a leave of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence

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

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Group Sponsored Insurance Plan and HRE Plan coverage, then you may pay your share of the contributions in one of the following ways:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- Pre-pay with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
- Pay-as-you-go with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or
- Under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If your Employer requires all Participants to continue Group Sponsored Insurance Plan and HRE Plan coverage during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Employer agree to. If your Group Sponsored Insurance Plan or HRE Plan coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

But, despite the preceding sentence, with regard to the HRE Plan, if your coverage ceased you will be permitted to elect whether to be reinstated in the HRE Plan at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated HRE Plan will equal the amount withheld before FMLA leave.

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

Non-FMLA Leaves of Absence

If you go on an unpaid leave of absence that does not affect your Group Sponsored Insurance and HRE Plan eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
- With their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or
- Under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

“Use it or Lose it”

This is a key point you must understand: If you have set aside dollars through salary reduction in the HRE Plan and/or DCE Plan, and you do not use those dollars by the end of the Plan Year, you will lose those dollars.

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

Contributions allocated to one account under a Plan can only be used to pay claims for that Plan and no other. For example, amounts credited to your DCE account cannot be used to pay or reimburse you for an expense under the HRE Plan, even if your DCE account has money in it but your HRE account has none. Similarly, amounts credited to your HRE account cannot be used to pay or reimburse you for a dependent care expense under the DCE Plan, even if your HRE account has money in it but your DCE account has none.

You will forfeit any amounts in your account(s) that are not applied to pay expenses submitted by the 90th day following the Plan's period of coverage end date for which the election was effective. Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the account during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations.

How Benefits are Taxed

Generally, you may not be taxed. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. **This information is not intended to provide legal tax advice. You should consult your own personal tax advisor.**

The tax benefits that you receive depend on the validity of the claims that you submit. If you are reimbursed for a claim that is later determined to not be eligible under the Plan, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Plan constitutes an eligible expense that qualifies for the federal income tax exclusion. Any reimbursement that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your spouse also participates in a DCE, the maximum amount that you and your spouse together can exclude from taxable income is \$5,000.

How does enrollment in a Dependent Care Assistance Plan affect my taxes?

Using the Plan for reimbursement of dependent care expenses results in a reduction of your taxable salary; therefore, your tax payments are reduced. Depending on your income tax bracket, you may also be entitled to claim the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these (or a combination of the two), but you may not take a tax deduction of those expenses reimbursed under this Plan, or vice versa.

You must file a 2441 Child Care Tax Credit form with your annual tax filing. Your Employer is required to report the amount you elect to withhold from your salary on your IRS W-2 form. You must list the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

If I elect DCE benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCE Plan, although your dependent care expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. For example, if you elect \$3,000 in coverage under the DCE account and are reimbursed \$3,000, but you had dependent care Expenses totaling \$5,000, then you could count the excess \$2,000 when calculating the Dependent Care Tax Credit if you have two or more dependents.

Ask PSA if you need further information about which expenses are, and are not, likely to be reimbursable.

The Plan Can Be Changed

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

Although the Employer expects to maintain the Plan, it has the right to amend or terminate all or any part of the Plan at any time for any reason.

How to File a Reimbursement Request

If you have a claim under an insurance plan or policy, you should follow the claims procedure applicable to that plan or policy, as described in the applicable Plan Document or summary.

For claims associated solely with the Plan, you should file your claim for reimbursement as soon as possible after you have incurred the expense. A signed "Request for Reimbursement Form" is required for all requests that you submit via mail or fax. Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense and the amount of your expense. Note: In some instances, a statement from the provider that an HRE expense is medically necessary may be required.

Claims may be submitted the following ways:

- Electronically via our secure web portal: <https://hrbenefitsdirect.com/PSA>
- Faxed with a reimbursement form to (866) 446-6090
- Mailed with a reimbursement form to PO Box 2797, Portland, OR 97208

Claims will be paid up to 90 days after the Plan's period of coverage end date. Those submitted after the allowable year-end "run out" period may not be paid.

Note that it is not necessary for you to have actually paid the amount due for an expense; only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card plan (debit card, credit card, or similar method) to pay expenses from the HRE account, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

If you receive reimbursement and it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to the Plan. If you do not refund the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences for you.

Handling Denied Claims

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

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

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information you would need to validate your claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including your right to submit written comments, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals

You may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA, in writing, within 180 days of your claim denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied, and should include any additional items or information that you feel supports your claim. The appeal process will provide you with the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

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

PSA will review your appeal in a reasonable time, but within 60 days after receiving your request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze your appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of your claim, you will receive a notice of that determination, which will include the following elements:

- The specific reason or reasons for the decision on review;
- The specific Plan provision or provisions that motivated the decision;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If internal rules, guidelines, protocols, or other similar criteria (collectively referred to as "internal guidelines") are relied on in making the decision on review, a description of the

specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to you upon request; and

- A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

ERISA Rights

As a Participant in the Plan (not including the DCE Plan, which is not covered by ERISA), you may be entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA does not apply to Employee benefit plans sponsored by governmental entities or churches. If your Employer is a church or governmental organization (such as a city or school district), ERISA will not apply and you will not have the rights described in this section.

ERISA provides that Plan Participants are entitled to:

- Examine, without charge, at the Employer's office and at other specified locations, such as work-sites and union halls, all Plan Documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all Plan Documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Employer is required by law to furnish each Participant with a copy of this Summary Plan Description.

Fiduciary Obligations

In addition to creating rights for Plan Participants, ERISA imposes duties upon the Employer who is responsible for the operation of an Employee benefit plan. The Employer is called the "fiduciary" of the Plan, and has a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan, or from exercising your rights under ERISA.

Right to Review

If your claim for a 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, you must submit this request to PSA, in writing, 180 days of the date of notice of your claim denial.

Enforcing your rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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 control of the Employer. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order

the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

COBRA Rights *(if applicable)*

An Employee who ceases to be eligible to participate in the Plan because of a termination of employment or a reduction of hours has the right to continue participation pursuant to a law known as "COBRA." COBRA rights also apply to an Employee's spouse and dependents that may lose eligibility under the Plan for reasons such as a divorce, as an example. While COBRA allows continued participation in the Plan, it requires the Employee (or the spouse or dependent, as the case may be) to pay for the coverage. Payment of the applicable "premium" would be with after-tax dollars. You will be provided additional information about your COBRA rights when you experience an event that would give rise to COBRA continuation coverage.

HIPAA Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), requires that the Plan protect the confidentiality of your private health information. The Plan and your Employer, as sponsor of the Plan, will not use or further disclose information that is protected under HIPAA (Protected Health Information or PHI) except as necessary for treatment, payment, healthcare operations and Plan administration, or as permitted or required by law.

As required under HIPAA, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without a written authorization from you, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employment benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your PHI, including the right to review and copy the information, receive an accounting of any disclosures of the information and, under certain circumstances, amend the information. You also have a right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

VI. Notices Required by Law

Qualified Medical Child Support Order

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

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)

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 to 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 her 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 from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law

"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others imposes strict confidentiality requirements and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

What is a Qualified Reservist Distribution?

A Qualified Reservist Distribution permits you to take a distribution of the amount you have contributed to the Plan (less reimbursements you have received or distributions previously taken) as of the date you request the distribution. If you are ordered or called to active military duty for 180 days or more you may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. You must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year (or Grace Period, if applicable) during which the order or call to active duty occurred. A Qualified Reservist Distribution is included in your gross income and wages, and is subject to employment taxes. You may submit expenses incurred after the date a Qualified Reservist Distribution has occurred. The amount that may be reimbursed is the amount by which you have elected to reduce your Compensation, less the sum of the Qualified Reservist Distribution and the amount of the reimbursements you received as of the date of the Qualified Reservist Distribution.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Employer.