

TOWN OF SUMMERVILLE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION



It is the sole responsibility of the plan administrator to provide plan participants with SPDs. In an effort to assist you in fulfilling this responsibility, Guardian is providing this sample document, however Guardian does not intend to provide you with legal advice regarding your obligations under ERISA, nor are we permitted to do so. Guardian makes no representations that the document meets all requirements for an SPD in ERISA and its regulations. You should review this document carefully to ensure you are meeting your legal requirements. If you have any questions regarding ERISA or your obligations under the law, you must seek the advice of your own legal counsel.

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TABLE OF CONTENTS

GENERAL INFORMATION ABOUT THE PLAN 1

PART I: QUESTIONS AND ANSWERS.....2

Q-1. WHAT IS THE PURPOSE OF THE PLAN? 2

Q-2. WHO CAN PARTICIPATE IN THE PLAN? 2

Q-3. WHEN DOES MY PARTICIPATION IN THE PLAN END? 2

Q-4. HOW DO I BECOME A PARTICIPANT? 3

Q-5. WHAT TAX ADVANTAGES ARE AVAILABLE THROUGH THE PLAN? 3

Q-6. WHAT ARE THE ELECTION PERIODS FOR ENTERING THE PLAN? 4

***Q-7. HOW ARE MY CONTRIBUTIONS UNDER THE BENEFIT PACKAGE OPTION(S)
MADE? 4***

Q-8. CAN I EVER CHANGE MY ELECTION DURING THE PLAN YEAR? 5

Q-9. HOW LONG WILL THE PLAN REMAIN IN EFFECT? 9

Q-10. WHAT HAPPENS IF MY CLAIM FOR BENEFITS UNDER THIS PLAN IS DENIED? 9

***Q-11. WHAT EFFECT WILL PLAN PARTICIPATION HAVE ON SOCIAL SECURITY AND
OTHER BENEFITS?..... 9***

Q-12. WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE? 9

PART II: OTHER IMPORTANT INFORMATION ABOUT THE CAFETERIA PLAN..... 10

HEALTH FSA APPENDIX TO THE FLEXIBLE BENEFIT PLAN SPD	1
PART I: QUESTIONS & ANSWERS.....	1
Q-1. WHO CAN PARTICIPATE IN THE HEALTH FSA?	1
Q-2. HOW DO I BECOME A PARTICIPANT?	1
Q-3. WHAT IS MY HEALTH CARE ACCOUNT?.....	2
Q-4. WHEN DOES COVERAGE UNDER THE HEALTH FSA END?	2
Q-5. CAN I EVER CHANGE MY HEALTH FSA ELECTION?	3
Q-6. WHAT HAPPENS TO MY HEALTH CARE ACCOUNT IF I TAKE AN APPROVED LEAVE OF ABSENCE?	3
Q-7. WHAT IS THE MAXIMUM ANNUAL HEALTH CARE REIMBURSEMENT THAT I MAY ELECT UNDER THE HEALTH FSA, AND HOW MUCH WILL IT COST?	3
Q-8. HOW DO I PAY FOR HEALTH CARE REIMBURSEMENT BENEFITS?	3
Q-9. WHAT AMOUNTS WILL BE AVAILABLE FOR HEALTH CARE REIMBURSEMENT AT ANY PARTICULAR TIME DURING THE PLAN YEAR?	4
Q-10. HOW DO I RECEIVE REIMBURSEMENT UNDER THE HEALTH FSA?	4
Q-11. WHAT IS AN ELIGIBLE MEDICAL EXPENSE?.....	6
Q-12. WHEN MUST THE EXPENSES BE INCURRED FOR WHICH I MAY BE REIMBURSED? 7	
Q-13. WHAT IF THE ELIGIBLE MEDICAL EXPENSES I INCUR DURING THE PLAN YEAR ARE LESS THAN THE ANNUAL AMOUNT I HAVE ELECTED FOR HEALTH CARE REIMBURSEMENT?	8
Q-14. WHAT HAPPENS IF A CLAIM FOR BENEFITS UNDER THE HEALTH FSA IS DENIED? 8	
Q-15. WHAT HAPPENS TO UNCLAIMED HEALTH CARE REIMBURSEMENTS?	8
Q-16. WHAT IS COBRA CONTINUATION COVERAGE?.....	8
Q-17. WILL MY HEALTH INFORMATION BE KEPT CONFIDENTIAL?	10
Q-18. HOW DOES THIS HEALTH FSA INTERACT WITH A HEALTH REIMBURSEMENT ARRANGEMENT SPONSORED BY MY EMPLOYER?	11
Q-19. HOW LONG WILL THE HEALTH FSA REMAIN IN EFFECT?	11

<i>DEPENDENT CARE FSA APPENDIX TO THE FLEXIBLE BENEFIT PLAN SPD</i>	13
<i>PART I: QUESTIONS & ANSWERS</i>	13
<i>Q-1. WHO CAN PARTICIPATE IN THE PLAN?</i>	13
<i>Q-2. HOW DO I BECOME A PARTICIPANT?</i>	13
<i>Q-3. WHAT IS MY DEPENDENT CARE ACCOUNT?</i>	13
<i>Q-4. WHEN DOES MY COVERAGE UNDER THE DEPENDENT CARE FSA END?</i>	13
<i>Q-5. CAN I EVER CHANGE MY DEPENDENT CARE FSA ELECTION?</i>	13
<i>Q-6. WHAT HAPPENS TO MY DEPENDENT CARE ACCOUNT IF I TAKE AN UNPAID LEAVE OF ABSENCE?</i>	14
<i>Q-7. WHAT IS THE MAXIMUM REIMBURSEMENT AMOUNT THAT I MAY ELECT UNDER THE DEPENDENT CARE FSA?</i>	14
<i>Q-8. HOW ARE AMOUNTS ALLOCATED TO THE DEPENDENT CARE FSA WITHHELD FROM MY PAY?</i>	14
<i>Q-9. WHAT AMOUNTS WILL BE AVAILABLE FOR REIMBURSEMENT OF ELIGIBLE DAY CARE EXPENSES AT ANY PARTICULAR TIME DURING THE PLAN YEAR?</i>	14
<i>Q-10. HOW DO I RECEIVE REIMBURSEMENT UNDER THE DEPENDENT CARE FSA?</i>	14
<i>Q-11. WHAT ARE "ELIGIBLE DAY CARE EXPENSES"?</i>	15
<i>Q-12. WHEN MUST THE EXPENSES BE INCURRED IN ORDER TO RECEIVE REIMBURSEMENT?</i>	16
<i>Q-13. WHAT IF THE ELIGIBLE DAY CARE EXPENSES I INCUR DURING THE PLAN YEAR ARE LESS THAN THE ANNUAL AMOUNT I HAVE ALLOCATED TO THE DEPENDENT CARE FSA?</i>	16
<i>Q-14. WHAT HAPPENS IF A CLAIM FOR BENEFITS UNDER THE DEPENDENT CARE FSA IS DENIED?</i>	17
<i>Q-15. WHAT HAPPENS TO UNCLAIMED DEPENDENT CARE FSA REIMBURSEMENTS?...</i>	17
<i>Q-16. WILL I BE TAXED ON THE DEPENDENT CARE FSA REIMBURSEMENT I RECEIVE?</i>	17
<i>Q-17. IF I PARTICIPATE IN THE DEPENDENT CARE FSA, WILL I STILL BE ABLE TO CLAIM THE HOUSEHOLD AND DEPENDENT CARE CREDIT ON MY FEDERAL INCOME TAX RETURN?</i>	17
<i>Q-18. WHAT IS THE HOUSEHOLD AND DEPENDENT CARE CREDIT?</i>	17
PLAN INFORMATION APPENDIX TO THE SUMMARY PLAN DESCRIPTION	18
I. EMPLOYER/PLAN SPONSOR INFORMATION	18
II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, AND ELECTIONS	19
III. BENEFIT PACKAGE OPTION(S) PROVIDED UNDER THE PLAN	19
IV. GRACE PERIOD	23
V. CLAIMS AND APPEAL PROCEDURES	26

**TOWN OF SUMMERSVILLE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION ("SPD")**

General Information About the Plan

Town Of Summersville (the "Employer") is pleased to sponsor an employee benefit program known as the Flexible Benefits Plan (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to as "Benefit Package Options") according to your individual needs, and allows you to use pre-tax dollars to pay for them by entering into a salary reduction arrangement with the Employer. This Plan helps you because the benefits you elect are nontaxable (i.e., you save social security and income taxes on the amount of your salary reduction). Alternatively, to the extent described in your enrollment materials, you may choose to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

In addition, the Employer has also established a Health Flexible Spending Account ("Health FSA") and a Dependent Care Flexible Spending Account ("Dependent Care FSA") that is offered under this Plan. Under the Health and Dependent Care FSA, you determine the amount of unreimbursed eligible medical and/or eligible day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year and you elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. You must elect wisely because any amounts allocated to the Health and/or Dependent Care FSA that are not used for expenses incurred during the plan year (and during the grace period following the end of the plan year to the extent a grace period is adopted by the Employer) will generally be forfeited.

Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this SPD. You will be referred to the Plan Information Appendix throughout the SPD.

This SPD and the attached Appendices (collectively, the SPD) describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

The effective date of this SPD is set forth in the attached Plan Information Appendix.

**Town Of Summerville
Flexible Benefit Plan
Summary Plan Description**

PART I: Questions and Answers

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits called "Benefit Package Options" with pre-tax dollars called "Pre-tax Contributions". The Benefit Package Options that may be paid for with Pre-tax Contributions under this Plan are described in the Plan Information Appendix. Pre-tax Contributions are described in more detail in Q-7 of this Part I.

To the extent Health Savings Accounts are identified as a Benefit Package Option offered under the Plan, you may be able to contribute to your personal Health Savings Account (as defined in Code Section 223) under this Plan with Pre-tax Contributions. If you are permitted to contribute to a Health Savings Account under this Plan, the rules regarding Health Savings Account contributions will be in accordance with Q-5 of the Plan Information Appendix.

Q-2. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Appendix) who satisfies the Plan Eligibility requirements described in the Plan Information Appendix and who is eligible to participate in any of the Benefit Package Options offered under the Plan will be eligible to participate in this Plan on the Plan Eligibility Date described in the Plan Information Appendix. (See Q-4 for instructions on how to become a participant.) Those employees who actually participate in the Plan are called "Participants". Your participation becomes effective as of the first pay period coinciding with or next following the date that your election is received or the date that you satisfy the Plan Eligibility Requirements, whichever is later. Generally, the Pre-tax Contributions will only relate to Benefit Package Option coverage provided on and after that date (i.e. the election is prospectively effective); however, if you are eligible for Benefit Option coverage on the date of hire and you are provided no more than 30 days to make your election during the Initial Election Period, then the Pre-tax Salary Reductions may relate to the coverage beginning and after the date of hire (i.e. the election is retroactively effective). See Q-4 for more information on elections and effective dates.

The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Package Options offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Package Options, please refer to the plan summary of each of the Benefit Package Options listed in the Plan Information Appendix. If you do not have summaries for each of the Benefit Package Options, you should ask the plan administrator of each Benefit Package Option(s) for copies.

Only coverage for an Employee and the Employee's "dependents" may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code and the Employee's tax dependents as defined in the Code Section applicable to that particular Benefit Package Option. For purposes of Health and Dependent Care FSA benefits offered under the Plan, see the definition of "Dependent" in the Health FSA Appendix and the Dependent Care FSA Appendix.

Q-3. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-8 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Appendix; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will *automatically* cease, and you will not be able to make any more Pre-tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the individual is permitted to continue a Benefit Package Option on a pre-tax basis out of severance pay). If you are rehired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility subject to any limitations imposed by the Benefit Package Option(s). If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year (subject to any applicable waiting period imposed by the Benefit Plan).

Q-4. How do I become a participant?

You become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay for the Benefit Package Options that you choose with Pre-tax Contributions. You will be provided with a Salary Reduction Agreement on or before your eligibility date described in the Plan Information Appendix. You must complete the form and submit it to the Plan Administrator or its designated Third Party Administrator (as identified in the Plan Information Appendix), during one of the election periods described in Q-6 below. You cannot become a participant in this Plan prior to the date you complete the Salary Reduction Agreement and submit it to the appropriate person(s). The effective date of coverage under the Benefit Package Options will be effective as set forth in the governing documents for the component Benefit Package Options. You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What tax advantages are available through the Plan?

Suppose your monthly gross pay is \$2,500 per month and your cost for coverage is \$140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$1,794. However, under the pre-tax premium plan, you will be considered to have received \$2,360 gross pay rather than \$2,500 for tax purposes with \$140 contributed for medical coverage. This means your take home pay will be \$1,825 with the pre-tax premium plan rather than \$1,794 without it. Thus, you save \$31 per month (\$372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	\$2,500	\$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	<u>2,360</u>	<u>2,500</u>

Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	<u>140</u>
Take Home Pay	<u>1,825</u>	1,794

Monthly Savings: \$31.00

Q-6. What are the election periods for entering the Plan?

When you are first hired, you must enroll during the "Initial Election Period" described in the Plan Information Appendix or the enrollment material in order to become a Participant in the Plan. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a change in status event described in Q-8 below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year; however, you may nevertheless be covered by certain Benefit Package Options automatically. These automatic Benefit Package Options are called "Default Benefits" and are identified in the enrollment material that you receive. Your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. If there are no Default Benefits, then you will have no coverage under the Benefit Package Options offered under this Plan if you fail to make an election under this Plan.

The Plan also has an "Annual Election Period" during which you may enroll (if you did not enroll during the Initial Election Period), continue your previous election or change your previous elections for the next Plan Year. The Annual Election Period will be identified in the Plan Information Appendix or the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a change in status event described in Q-8 below. If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue participation in the Plan with the same Benefit Package Option elections in effect on the last day of the Plan Year in which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election". Alternatively, the Plan Administrator may deem you to have elected not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The consequences of failing to make an election during the Annual Election Period will be described in the Plan Information Appendix. You must make an election each Annual Election Period in order to participate in the Health and/or Dependent Care FSA and/or continue contributing to your Health Savings Account (if offered through the plan) with Pre-tax Contributions. Evergreen Elections do not apply to FSA and/or Health Savings Account elections (if made available under this Plan).

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

Q-7. How are my contributions under the Benefit Package Option(s) made?

When you become a Participant, your share of the contributions for the elected Benefit Package Option(s) will be paid with Pre-tax Contributions that you elected to make on the Salary Reduction Agreement or Election Form. To the extent set forth in the enrollment material, you may be required to pay for any Benefit Package Options that you elect with Pre-tax Contributions. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted. In addition, all or a portion of the cost of the Benefit Package Options may, in the Employer's discretion, be

paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may provide you with Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Package Options that you choose (subject to restrictions described in the enrollment material). In this case, the Nonelective Contributions may be referred to as "Benefit Credits."

Q-8. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution and/or Nonelective Contribution allocated thereto by you (if applicable) for Benefit Package Options you have elected during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections for Pre-tax Contributions only during the Annual Election Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator identified in the Plan Information Appendix within the election change period set forth in the Plan Information Appendix, following the events described below. **Note:** If you elect to contribute to a Health Savings Account (to the extent permitted under this Plan and identified as a Benefits Option in the Plan Information Appendix), there are special rules regarding mid-year election changes, See the Health Savings Account Contribution Appendix for more information on Health Savings Account elections made under this Plan.

1. Change in Status. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse),
- a change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit **NOTE: the rules governing election changes when you take a leave of absence are described in Q-12 of this SPD,**

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student),
- a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election within 31 days of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator (or its designated Third Party Administrator). With the exception of a HIPAA special enrollment right as noted in the SPD, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or your dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your spouse involved in the divorce, annulment, or legal separation, your deceased spouse or dependent, or your dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.
- Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.
- However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a dependent. Contact the Plan Administrator for more information.
- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit package option) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan.* See the list of Benefit Package Options offered under the Plan in the

Plan Information Appendix). For group term life insurance, disability income and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

- *Dependent Care Reimbursement Plan Benefits.* With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

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

2. HIPAA Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a Benefit Package Option that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights. If an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or SCHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a benefit plan option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Please refer to the group health plan summary description for an explanation of special enrollment rights. Note: This only applies to a Health FSA to the extent that the Health FSA is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3. Certain Judgments, Decrees and Orders. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

4. Entitlement to Medicare or Medicaid. If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. Change in Cost. If you are notified that the cost of your Benefit Package Option coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Package Option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Health FSA, to the extent offered under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. Change in Coverage. If you are notified that your Benefit Package Option coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Package Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Health FSA, to the extent offered under the Plan.)

Additionally, your election(s) may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-9. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program 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.

Q-10. What happens if my claim for benefits under this Plan is denied?

See the Claims Procedures section set forth in the Plan Information Appendix.

Q-11. What effect will Plan participation have on 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 benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-12. What happens if I take a leave of absence?

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided 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, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- (c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that you may not use Pre-tax Contributions to pre-pay coverage during the next Plan Year (except as otherwise permitted by applicable law, regulations and/or guidance). In addition, you may make contributions by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- (g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Q-8 of this Part I will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

PART II: Other Important Information about the Cafeteria Plan

Participation in the Plan does not give any participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan.

The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix attached to this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information has been provided in the Plan Information Appendix attached to this SPD.

**Health FSA Appendix to the
TOWN OF SUMMERSVILLE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION**

Health Flexible Spending Account Summary Plan Description

General Information about the Health Flexible Spending Account

You will have the opportunity to elect to receive income tax-free reimbursement ("Health Care Reimbursements") for some or all of your unreimbursed health care expenses ("Eligible Medical Expenses") under the Health Flexible Spending Account ("Health FSA"). Under the Health FSA, you purchase a specific level of Health Care Reimbursement benefits and you pay for such Health Care Reimbursements with Pre-tax Contributions.

Part I: Questions & Answers

Q-1. Who can participate in the Health FSA?

Each employee who satisfies the Health FSA Eligibility requirements described in the attached Plan Information Appendix is eligible to participate in the Health FSA on the Health FSA Eligibility Date described in the Plan Information Appendix.

Q-2. How do I become a Participant?

You become a participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods. (The Initial and Annual Election Periods are described in Q-6 of Part I of the Flexible Benefit Plan SPD). Your participation in the Health FSA will be effective on the date that you make an election or your Health FSA Eligibility Date (as described in the Plan Information Appendix), whichever is later. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-8 of Part I of the Flexible Benefit Plan SPD. You must make an election during the annual Election Period in order to participate during the next Plan Year. Evergreen elections described in Q-6 of Part I of the Flexible Benefit Plan SPD do not apply.

Once you become a Participant, you may also receive reimbursements for Eligible Medical Expenses incurred by your "Eligible Dependents".

For purposes of the Health FSA, Eligible Dependents are the following:

- i. Your legal Spouse and
- ii. any other individuals who would qualify as a tax Dependent under Code Section 105(b).

Whether an individual is your Spouse will be determined in accordance with the Code. An individual is a "dependent" for purposes of Code Section 105(b) if the individual satisfies any of the following criteria: (i) the individual is a dependent for income tax purposes under Code Section 152 (i.e. qualifies you for a personal exemption); (ii) the individual would qualify as your dependent under Code Section 152 but for the fact that (A) the individual has income in excess of the exemption amount (applicable to "Qualifying Relatives" as defined in Code Section 152), (B) you are a dependent of another taxpayer, or (C) the

individual is married and files a joint return with his or her spouse; or (iii) Effective March 30, 2011, the individual is a "child" as defined by Code Section 152(f)(1) who will not turn age 27 during the year (i.e. through end of the calendar year in which the "child" turns age 26). An individual qualifies as a child as defined by Code Section 152(f) (1) if he/she is any of the following: (i) natural child; (ii) adopted child or child "placed with you for adoption" (iii) step child or (iv) child placed with you by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. In addition, a child to whom Section 152(e) applies (i.e. a child of divorced or separated parents) is considered a dependent of both parents for the purpose of the Health FSA without regard to who claims the child as a dependent on his or her tax return.

If the Plan Administrator receives a qualified medical child support order relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order (to the extent such coverage is provided under the Health FSA). "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a "qualified medical child support order" to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE: Your participation in this Health FSA could disqualify your Spouse from establishing a health savings account as defined in Code Section 223 or from making/receiving tax favored contributions to a health savings account unless you elect to participate in the limited reimbursement option set forth below.

Q-3. What is my "Health Care Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing health care account will be set up to keep a record of the reimbursements you are entitled to, as well as the contributions you have made for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-4. When does coverage under the Health FSA end?

You continue to participate in the Health FSA until (i) you elect not to participate in accordance with Q-8 of Part I of the Flexible Benefit Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period to continue participating during the next Plan Year (there are no Evergreen Elections for the Health FSA); (iii) you no longer satisfy the eligibility requirements described in the Appendix; (iv) you terminate employment with the employer; or (v) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. You may be entitled to elect Continuation Coverage (as described below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earliest of the following to occur: (i) the date your coverage ends; (ii) for your spouse, the date that you and your spouse divorce or legally separate (or receive an annulment); (iii) the date an individual ceases to meet the requirements of an Eligible Dependent; or (iv) the date the Plan is terminated or amended to exclude the individual or the class of dependents of which the individual is a member. Your covered dependents may also be entitled to

continue coverage if coverage is lost for certain reasons. See Q-16 of Part I of this Health FSA Appendix to the Flexible Benefit Plan SPD for more information on COBRA.

If you cease to be a participant because you terminate employment and you are rehired during the same Plan Year, the sum of your new election (to the extent you are permitted to make a new election in accordance with Q-3 of Part I of the Flexible Benefit Plan SPD) and the amount of reimbursements you received prior to your termination of employment cannot exceed the maximum annual reimbursement amount permitted under this Health FSA, as set forth in the Plan Information Appendix.

Q-5. Can I ever change my Health FSA election?

You may change your Health FSA election during the Annual Election Period for any reason. You may change your Health FSA election during the Plan Year only under certain conditions set forth in Q-8 of Part I of the Flexible Benefit Plan SPD. Notwithstanding anything in Q-8 of Part I of the Flexible Benefit Plan SPD, you may not reduce your Health FSA election during the Plan Year below the reimbursements that you have already received.

Any change in your election affecting annual contributions to the Health FSA will change the maximum available reimbursement for the remainder of the Plan Year. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-6. What happens to my Health Care Account if I take an approved leave of absence?

Generally, the rules described in Q-12 of Part I of your Flexible Benefit Plan SPD apply. However, if your Health FSA coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the Health FSA, at the same coverage level 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 make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7. What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may choose any annual Health Care Reimbursement amount you desire, subject to the maximum annual Health Care Reimbursement amount and minimum reimbursement amount described in the Plan Information Appendix. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Nonelective Employer Contribution allocated to your Health Care Account.

Any change in your election affecting annual contributions to the Health Care Account pursuant Q-8 of Part I of Flexible Benefit Plan SPD also will change the maximum available reimbursements for the period of coverage remaining in the Plan Year. See Q-5 of Part II of this SPD for more information on how election changes impact your annual reimbursement.

Q-8. How do I pay for Health Care Reimbursement benefits?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of

the annual contribution, reduced by any Nonelective Employer Contributions allocated to your Health Care Account, will be deducted from each paycheck by your Employer.

Q-9. What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

Provided that you continue to pay the periodic contributions due for this benefit, the full, annual amount of Health Care Reimbursement you have elected will be available at any time during the Plan Year, reduced by the amount of previous Health Care Reimbursements received during the Plan Year.

Q-10. How do I receive reimbursement under the Health FSA?

Under this Health FSA, you may have two reimbursement options. You can complete and submit a written claim for reimbursement (“Traditional Paper Claims”). Alternatively, you may be able to use an electronic payment card (“Electronic Payment Card” or “Card”) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the “Program”) as set forth herein and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in the program, limitations as to Card usage, the Plan’s right to withhold and offset for ineligible claims, etc). The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form unless an Explanation of Benefits (EOB) form is provided directly to the Third Party Administrator by the applicable insurance carrier or medical/dental plan administrator. If the EOB is provided directly to the Third Party Administrator, you do not need to file a claim with Third Party Administrator; it is deemed filed when the Third Party Administrator receives the claim. You will be notified in the enrollment material of this plan if an EOB will be provided directly to the Third Party Administrator. If you are required to file a claim, you may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, explanation of benefits or “EOB”, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of expense (e.g., what type of service or treatment was provided).
4. If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy that has the RX number provided by the pharmacist and the identity of the individual for whom the prescription was issued.
5. Amount of reimbursable expense under the plan
6. Date(s) of service

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an “Eligible Medical Expense” you will receive notification of this determination (see “What happens if my claim for benefits is denied” Q-14 below). You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the Run Out Period. The Run-out Period is described in the Plan Information Appendix.

NOTE: If your health plan administrator or insurance carrier automatically submits an EOB to the Third Party Administrator for processing, you may not have to provide any additional substantiation or certification.

Electronic Payment Card (if available under the Plan):

If your employer offers this option, the Electronic Payment Card “Card” allows you to pay for Eligible Expenses and Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works. NOTE: The Plan Administrator reserves the right to offer the Card for use under one option or the other but not both.

(a) *You must make an election to use the card.* In order to be eligible for the Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Cardholder Agreement issued in conjunction with the Card, including any fees applicable to participate in the Program, limitations as to Card usage, the Plan’s right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program when you first enroll and during each Annual Election Period. The Card will not be activated if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period.

(b) *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the Card will only be used for Eligible Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) *Reimbursement under the Card is limited to certain merchants.* Use of the Card is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. In addition, the Card will be administered in accordance with applicable IRS guidance.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Expense at an eligible merchant, such as a co-payment or prescription drug expense you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available under the Health Care Account. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the merchant (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The date the expense was incurred or the period during which the services were provided
- The amount of the expense.
- Explanation of Benefits (EOB)

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is generally required to be submitted (except as otherwise provided in the Cardholder Agreement or as

otherwise permitted under applicable law and associated guidance). You will receive a notification from the Claims Administrator if a third party statement is needed. You must provide the third party statement to the Claims Administrator within the period identified in the notification from the Claims Administrator. **NOTE:** If you purchase an over the counter drug or medicine with your Card from a merchant that does not utilize the Inventory Information Approval System, you may be required to present to the third party administrator a copy of the prescription or, alternatively, a copy of the receipt that has the RX number and the identity of the individual for whom the prescription was issued. Use of the Card may be subject to additional restrictions established by the third party administrator.

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense as set forth below and/or the claims administrator may offset the unsubstantiated transaction against other eligible expenses submitted for reimbursement. In addition, your usage of the card may be terminated by the Employer until such time as you have repaid the expense.

(h) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Q-11. What is an "Eligible Medical Expense?"

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- i. The expense is for "medical care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator;
- ii. The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. Over-the-counter drugs and medicines (other than insulin) that are for "medical care" will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription that complies with applicable state law from an authorized health care provider (e.g. physician or, where permitted by law, a physician's assistant). Insulin and over-the-counter devices and supplies (other than drugs or medicines) will still constitute an Eligible Medical Expense, even if not prescribed by a health care provider, to the extent they are otherwise for "medical care". "Stockpiling" of over the counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must

be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute “medical care” as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- i. Health insurance premiums;
- ii. Expenses incurred for qualified long term care services; and
- iii. Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix.

If you currently maintain or wish to establish a personal Health Savings Account (Limited Reimbursement Option)

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute “medical care” as defined in Code Section 213(d)):

- (i) Services or treatments for dental care (excluding premiums)
- (ii) Services or treatments for vision care (excluding premiums)
- (iii) Services or treatments for “preventive care”. Preventive care is defined in accordance with applicable rules and regulations. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic) (b) to prevent the recurrence of a condition from which the eligible individual has recovered or (c) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

A Health FSA participant may make an election during the annual enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to the medical expenses described in this Limited Reimbursement Option section.

Newborns' and Mothers' 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 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).

Q-12. When must the expenses be incurred for which I may be reimbursed?

Eligible Medical Expenses must be incurred *during* the Plan Year and while a participant. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year (unless the Employer has adopted a grace period following the end of the Plan Year), or,

after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

If the Employer has adopted a grace period or carryover, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year in a subsequent plan year(s). The terms of the “grace period,” or “carryover” if adopted, will be described in the Plan Information Appendix

Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the Run Out Period (described in the Plan Information Appendix) to provide the elected benefit for any Plan Year. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a grace period or carryover following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during a subsequent plan year(s) in accordance with the Plan information Appendix. Any amounts not used for expenses incurred during the Plan Year and during the grace period will be forfeited

Q-14 What happens if a Claim for Benefits under the Health FSA is denied?

- See the Claims Procedure section set forth in the Plan Information Appendix.

Q-15. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Q-16. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health FSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

When Coverage May Be Continued

If you are a participant in the Health FSA, then you generally have a right to choose continuation coverage under the Health FSA if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events". Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries". A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator identified in the Plan Information Appendix in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents that reside with the spouse.

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Appendix of this SPD. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the qualifying event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The first day of the month following the month for which you made a timely and complete premium payment (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or \$50, you will be given 30 days to cure the shortfall),
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation *after you have elected COBRA continuation coverage*,
- The date that you first become entitled to Medicare *after you have elected COBRA continuation coverage*; or
- The date the Employer no longer provides group health coverage to any of its employees.

Q-17. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-18. How does this Health FSA interact with a Health Reimbursement Arrangement Sponsored by my Employer?

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Appendix will indicate whether the Health FSA or HRA must pay first.

Q-19. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Health FSA indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Participation in the Plan does not give any participant the right to be retained in the employ of his or her Employer or any other right not specified in the Health FSA.

The Plan Administrator's name, address and telephone number appear in the Appendix to this Summary. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan.

ERISA Rights

The Health FSA Plan may be an ERISA welfare benefit plan. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, 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 all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan 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

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-16 of Part I of this Health FSA Appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the **Plan** when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

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 the 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 from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that 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

If you have any questions about the 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 obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 (EBSA).

**DEPENDENT CARE FSA APPENDIX TO THE
TOWN OF SUMMERVILLE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION**

General information about Dependent Care Reimbursement Plan

You will have the opportunity to elect to receive income tax free reimbursement (“Dependent Care Reimbursement”) for some or all of your unreimbursed work related day care expenses (“Eligible Day Care Expenses”) under the Dependent Care Flexible Spending Account Dependent Care FSA. Under the Dependent Care FSA, you purchase a specific level of Dependent Care Reimbursement benefits and you pay for such coverage with Pre-tax Contributions.

Part I: Questions & Answers

Q-1. Who can participate in the Plan?

Each employee who satisfies the Dependent Care FSA eligibility requirements described in the Plan Information Appendix is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date described in the Plan Information Appendix.

Q-2. How do I become a Participant?

You become a Participant by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods. The Initial and Annual Election Periods are described above in Q-6 of Part I of the Flexible Benefit Plan SPD. Your participation in the Dependent Care FSA will be effective on the date that you make an election or your Dependent Care FSA Eligibility date, whichever is later.

Q-3. What is my "Dependent Care Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing dependent care account will be set up to keep a record of the Dependent Care Reimbursements you are entitled to. The Dependent Care Account is not an actual account; it is merely a bookkeeping account.

Q-4. When does my coverage under the Dependent Care FSA end?

You continue to participate in the Dependent Care FSA until (i) you elect not to participate in accordance with Q-8 of Part I of the Flexible Benefit Plan SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Appendix; (iii) the end of the Plan Year unless you make an election to participate during the Annual Election Period; (iv) you terminate employment with the employer (there are special rules for terminating employees); or (v) the Plan is terminated or amended to exclude you or the class of Employees of which you are a member.

If you terminate employment during the Plan Year, you may submit for reimbursement Eligible Day Care Expenses incurred after the date of separation up to the amount of your Dependent Care Account at the time of your reimbursement.

Q-5. Can I ever change my Dependent Care FSA election?

You may change your Dependent Care FSA election during annual enrollment for any reason. You may change your Dependent Care FSA election during the Plan Year only under certain conditions set forth in Q-8 of Part I of the Flexible Benefit Plan SPD.

Q-6. What happens to my Dependent Care Account if I take an unpaid leave of absence?

Generally, the rules described in Q-12 of your Flexible Benefit Plan SPD apply to the Dependent Care FSA.

Q-7. What is the maximum reimbursement amount that I may elect under the Dependent Care FSA?

This annual amount cannot exceed the statutory maximum Dependent Care Reimbursement Amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently \$5,000 per Plan Year if you:

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Qualifying Individuals for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum reimbursement amount under the Dependent Care FSA that you may elect is \$2,500. Whether an individual is your Spouse is determined in accordance with the Code.

In addition, the amount of reimbursement that you receive cannot exceed the lesser of your or your spouse's earned income (as defined in Code Section 32). Except as otherwise permitted by law, your Spouse will be deemed to have Earned Income of \$250 (\$500 if you have two or more Qualifying Individuals) for each month that your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Q-8. How are amounts allocated to the Dependent Care FSA withheld from my pay?

When you complete the election form, you specify the amount of reimbursement for Eligible Day Care Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any Nonelective Employer Contributions (if any) allocated to your Dependent Care FSA sub-account, will be withheld from each paycheck by your Employer.

Q-9. What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

Under the Dependent Care FSA, you may be reimbursed only up to the amount of your Dependent Care FSA sub-account balance at the time the request for reimbursement is processed.

Q-10. How do I receive reimbursement under the Dependent Care FSA?

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The nature of the expense.
- The date or dates the services were provided.
- The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Day Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

Q-11. What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies (unless the Employer adopts the grace period).

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

- An individual age 12 or under who (i) has the same principal place of abode as you; (ii) does not provide over half of his/her own support; and (iii) is your "child" (son, daughter, grandchildren, step children, brother, sister, niece and nephew), or
- A Spouse or other tax dependent (as defined generally in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152 or (iii) the individual is married and files a joint return with his/her Spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the Qualifying Individual of the "custodial parent" (as defined in Code Section 152(e) (3)) without regard to which parent claims the child on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (or your Spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f) (1)) of yours who is under age 19 for the entire year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent. Moreover, the day care cannot be provided by a parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred *during* the Plan Year and while a participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Dependent Care FSA election becomes effective, or after a separation from service.

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in the Plan Information Appendix.

Q-13. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the Dependent Care FSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the Dependent Care FSA shall be forfeited by the Participant if it has not been applied by the end of the Run-out period to reimburse expenses incurred during the Plan Year. The Run-out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a grace period following the end of the Plan Year, amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the grace period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and the grace period will be forfeited.

Q-14 What happens if a Claim for Benefits under the Dependent Care FSA is denied?

If you are denied a benefit under the Dependent Care FSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-15. What happens to unclaimed Dependent Care FSA reimbursements?

Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

Q-16. Will I be taxed on the Dependent Care FSA reimbursement I receive?

You will not normally be taxed on your Dependent Care FSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this Dependent Care FSA and/or another employer's Dependent Care FSA) does not exceed the statutory limits set forth above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-17. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Day Care Expenses not reimbursed under this Dependent Care FSA may be eligible for the dependent care credit.

Q-18. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual Eligible Day Care Expenses as a credit against your federal income tax liability under the U.S. Tax Code. See Publication 503 for more detail.

**PLAN INFORMATION APPENDIX
to the
TOWN OF SUMMERVILLE
FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION**

This Appendix provides information specific to the Town Of Summerville Flexible Benefit Plan.

I. EMPLOYER/PLAN SPONSOR INFORMATION

1.Name, address, and telephone number of the Employer/Plan Sponsor:	Town Of Summerville 200 S Main Street Summerville, SC 29483 (843) 851-4202 Ext()
2.Plan Administrator Name:	Town Of Summerville
3.Employer's federal tax identification number:	57-6001110
4.Plan Number:	504
5. Agent for Service of Legal Process:	
6.Original Effective Date of the Plan:	January 01, 2001
7.Effective Date of Amendment/Restatement (if different from 5):	January 01, 2017
8. Plan Years:	01/01 - 12/31
9. Adopting Employers participating in the Plan:	
10 .Third Party Administrator:	The Guardian Life Insurance Company 3900 Burgess Place Bethlehem, PA 18017 (866) 359-4542 – Phone (610) 807-8830 – Fax flexplan@glic.com – Email www.guardiananytime.com - Website
11. COBRA Administrator	Next Generation 455 Pettis Ave Ada, MI 49301

II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, and ELECTIONS

(a) **Town Of Summerville Flexible Benefit Plan.** If you are eligible for one or more of the Benefit Package Options offered under the Plan, you are eligible to participate in this Plan. You become eligible to participate on the first date you become eligible for one or more of the Benefit Package Options. The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in the SPD.

(b) **Health FSA.** (If offered, see **Benefit Package Options** below) Each Employee working 30 or more hours per week shall be eligible to participate in the Health FSA on the first of the month following date of hire ("Health FSA Eligibility Date").

(c) **Dependent Care FSA.** (If offered, see **Benefit Package Options** below) Each Employee working 30 or more hours per week shall be eligible to participate in the Dependent Care FSA on the first of the month following date of hire ("Dependent Care FSA Eligibility Date").

(d) **Annual Elections.** With respect to Benefit Package Option elections (other than the Health FSA elections), failure to make an election during the Annual Election Period will result in the following deemed election(s) as selected below:

- The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Package Options offered under the Plan will end the last day of the Plan Year in which the Annual Election Period occurred; however, certain Benefit Package Options may nevertheless cover you automatically. These automatic Benefit Package Options are called "Default Benefits" and are identified in the enrollment material that you receive. Your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. If there are no Default Benefits, then you will have no coverage under the Benefit Package Options offered under this Plan if you fail to make an election under this Plan.
- The employee will be deemed to have elected to continue his Benefit Package Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place (this is called an "Evergreen election"). **NOTE: Evergreen elections do not apply to Health and/or Dependent Care FSA elections (and Health Savings Account, if permitted under the Plan).**

III. BENEFIT PACKAGE OPTION(S) PROVIDED UNDER THE PLAN

The Employer elects to offer to eligible Employees the following Benefit Package Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Package Options. These component Benefit Package Option(s) are specifically incorporated herein by reference. The maximum Pre-tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Package Options selected minus any Non-elective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

(a) **Benefit Package Options:** The following Benefit Package Options are made available under the Plan to all those eligible Employees who make an appropriate election.

Dependent Care Reimbursement Account

Medical Reimbursement Account

Supplemental Medical Plan / Dental

Major Medical Plan

Supplemental Medical Plan / Vision

Supplemental Medical Plan /Cancer

Supplemental Medical Plan / Accident

(b) **Cash Option.** Additional taxable compensation for certain Employees who opt-out of certain Benefit Package Options or who do not use the entire allotted amount of Non-elective Contributions, if offered under the plan will be set forth in the enrollment material.

(c) **Health Care Reimbursement**

(1) **Health Care Reimbursement - Generally.** The maximum annual Health FSA reimbursement shall not exceed the Pre-tax Contribution amount you may elect with respect to the Health FSA, or if greater, the sum of the Pre-tax Contribution amount you elect plus any additional nonelective Employer contributions that the Employer has agreed to make (as described in the enrollment materials). The maximum Pre-tax Contribution amount you may elect is \$2,600.00. In no event may the Pre-tax Contributions made with respect to the Health FSA (and all Health FSAs) maintained by the Employer (and any employer within the same controlled group, as defined by the Code) for a Plan Year exceed \$2,600.00. The minimum Pre-tax contribution amount that may be elected under the Health FSA is \$ 0.00. The minimum reimbursement amount is hereby set to be \$0.00. Eligible Medical Expenses must be submitted within 90 days following the end of the plan year.

(2) **Coordination between Health FSA and HRA.** See below regarding this Health FSA's rules with respect to coordination with an HRA sponsored by the Employer (if any):

Does the Employer sponsor an HRA?	No
Does this Health FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health FSA?	N/A

(d) **Dependent Care Reimbursement.** Dependent Care Reimbursement under the Dependent Care FSA shall not exceed the lesser of the amount elected under Plan or \$5,600.00 per Plan Year (or \$2,500 for married filing separate returns), pursuant to the terms of the Dependent Care FSA described in the Dependent Care Appendix of the SPD. The minimum Pre-tax contribution amount that may be elected under the Dependent Care FSA is \$ 0.00. The minimum reimbursement amount is hereby set to be \$0.00. Eligible Employment Related Expenses

incurred during the plan year must be submitted within 90 days following the end of the plan year.

- (e) **Health Savings Account** (the following only applies to the extent Health Savings Accounts are identified above as a Benefit Package Option offered under the Plan).

Q.1. What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account ("HSA") is a personal trust or custodial account established with a Custodian or Trustee to be used for reimbursement of "eligible medical expenses" incurred by the Account Beneficiary and his/her tax dependents, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee subject to the terms and conditions set forth in the Custodial or Trust Agreement between the Account Beneficiary and the Custodian or Trustee. The HSA is not an employee benefit plan sponsored or maintained by the Employer. The Employer's role with respect to the HSA is limited to making contributions through this Plan to the HSA established by you with the Custodian/Trustee (through Employer contributions and/or pre-tax salary reductions elected by you). The Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified in the Summary Plan Description and offered through this Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Q-2. Who is eligible for HSA contributions under this Plan?

HSA eligibility is determined under IRS rules and the applicable terms and conditions of any Custodial or Trust agreement. You are eligible for Plan contributions to your HSA during any month if you satisfy the following conditions on the first day of that month:

- (a) You are covered under a qualifying High Deductible Health Plan (as defined in Code Section 223) maintained by Employer;
- (b) You certify, in accordance with policies and procedures established by the Employer, that you satisfy all of the requirements to be an Eligible Individual as set forth in Code Section 223. You are required to notify the Employer if you fail to satisfy these conditions on the first day of any month following the date that you first certify that you meet these requirements. In addition to being covered under a qualifying High Deductible Health Plan maintained by Employer, you must not be (i) covered under any other health plan or program that is not a qualifying High Deductible Health Plan (as defined in Code Section 223) unless that coverage is limited to "permitted coverage," "permitted insurance" and/or preventive care as defined in Code Section 223 and related guidance; (ii) entitled to Medicare; or (iii) eligible to be claimed as a Dependent of any other taxpayer.
- (c) You are otherwise eligible for this Plan.

Q-3. Who is an Account Beneficiary?

An Account Beneficiary is an eligible Participant who has properly enrolled in their own HSA in accordance with the terms of the applicable Custodial Agreement.

Q-4. Who is a Custodian or Trustee?

The Custodian or Trustee is the entity with whom the Account Beneficiary's HSA is established (for purposes of this Plan, use of the term "Custodian" includes a reference to both Custodian and Trustee). The HSA is established pursuant to an agreement ("Custodial Agreement") between the Custodian and the Account Beneficiary. To the extent the Participant is an Eligible Individual as defined above, the Participant may establish an HSA with any Custodian; however, pre-tax HSA contributions and Employer HSA contributions, if any, that are made through this Plan will only be made to a Custodian designated by the Employer ("Designated Custodian"). The Participants who establish HSAs with the Designated Custodian will be permitted to rollover funds from the HSA offered through his Plan to another HSA chosen by the Account Beneficiary (in accordance with the terms of the Custodial Agreement).

Q-5. What are the rules regarding contributions made to an HSA under the Plan?

Contributions made under this Plan may consist of both pre-tax contributions made by you through this Plan and/or non-elective Employer contributions (if any) made through this Plan. You may elect to contribute any amount to the HSA up to the annual contribution limit established under Code Section 223 (the "Maximum Annual Contribution Amount"). The Maximum Annual Contribution Amount for an HSA offered under this Plan cannot exceed the sum of the "monthly limits" for each month during the Plan Year that you are an Eligible Individual (as described in Q-2 above). The monthly limit is 1/12 of the lesser of the statutory annual contribution amount established by Code Section 223 for the applicable level of coverage or such amount established under this Plan, for each month that you are an eligible individual. NOTE: There is a special rule for employees who become an Eligible Individual during the calendar year. If you are not an Eligible Individual (as defined in Q-2 above) for the entire calendar year but you are an Eligible Individual during the last month of the calendar year, then you are treated as being an Eligible Individual for the entire calendar year. For all months during the calendar year that you are treated as being an Eligible Individual solely as a result of this rule, you are considered as having the same coverage in effect in the last month of that year. You will be taxed on any contributions made to the HSA (and be subject to a 20% excise tax) under this rule for months that you were not an Eligible Individual if you cease to be an Eligible Individual during the "Testing Period". The testing period begins in December of the year in which you became an Eligible Individual and ends the last day of December of the following year.

The Maximum Annual Contribution amount will be prorated equally over the remaining pay periods following your effective date of coverage. No contributions will be withheld until you have provided evidence deemed sufficient by the Plan Administrator that you have established an HSA as set forth herein. If you are or will be age 55 or older before the end of the year and you properly certify your age to the Employer, the Maximum Annual Contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b) (3)), but only to the extent permitted in the separate written HSA material provided by the Employer and/or the Custodian.

Employer Contributions are not mandated but if made, such contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer and as communicated in Plan or HSA enrollment materials).

Your election to make HSA contributions through this Plan will not be effective until the later of the date that you make an HSA contribution election through this Plan (to the extent such election is approved by the Plan Administrator) or the date that you establish an HSA with the Custodian during the Plan Year (the effective date of the HSA is determined by the Custodian and/or applicable law). Employer may adjust contributions made under this Plan as necessary to ensure the Maximum Contribution Amount described above is not exceeded.

Any pre-tax salary reduction contributions that cannot be made to the HSA because it is determined that you are not an Eligible Individual (as described in Q-2 above), you have failed to establish an HSA with the Designated Custodian by December 31 (or such other date as determined by the Employer), or that the Maximum Annual Contribution amount has been exceeded will be returned to you as taxable compensation or as otherwise set forth in the Plan or Plan enrollment material. Any Employer Contributions that cannot be made to the HSA because you are not eligible for such contributions will be returned to the Employer except as otherwise set forth in the Plan or the Plan enrollment material.

Employer may advance contributions to you up to your annual HSA pre-tax salary reduction election made through this Plan (reduced by any prior pre-tax contributions made by you during the Plan Year) or such other amount established by the Employer, whichever is less. Advance contributions will be made available to all Participants on non-discriminatory terms and conditions; however, the Employer may condition the advance of such contributions on the occurrence of certain events identified by the Employer in separate written material relating to the Plan. Moreover, you will be required to repay the Employer for advances made through this Plan through means established by the Employer.

In the event excess contributions are made to the Participant's HSA (i.e. the HSA has received contributions in excess of the Maximum Annual Contribution Amount), it will be the sole responsibility of the Participant to work with the Custodian to remove the excess contribution (plus earnings on such contributions) prior to the due date of the Participant's tax return for that tax year and to report the contributions (and earnings) as income when filing taxes at the end of the year.

Q-6. Where can I get more information on my HSA and its related tax consequences?

For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA Custodial Agreement and/or the HSA communication material provided by your Employer.

IV. GRACE PERIOD Or CARRYOVER

A. Grace Period

The Employer **has not** adopted a Grace Period.

(If indicated above that the Employer has adopted the grace period, the following applies) The Employer has established a "grace period" for the Health FSA/Dependent Care FSA that follows the end of the Plan Year during which amounts you have allocated to the applicable spending account(s) that are unused at the end of the Plan Year may be used to reimburse eligible expenses (with respect to the applicable spending account) incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end two (2) months and fifteen (15) days later. For example, if the Plan Year ends December 31, 2014, the grace period begins January 1, 2015 and ends March 15, 2015.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed so as to change the order in which they were received.

For example, assume that \$200 remains in your Health FSA sub-account at the end of the 2014 Plan Year and further assume that you have elected to allocate \$2400 to the Health FSA for the 2015 Plan Year. If you submit an Eligible Medical Expense for reimbursement of \$500 that was incurred on January 15, 2015, \$200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2014 Plan Year and the remaining \$300 will be paid out of amounts allocated to your Health FSA for 2015.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. This is the same Run-out Period for expenses incurred during the Plan Year to which the grace period relates. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period.
- You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

B. Carryover

The Employer has adopted a Carryover.

(If indicated above that the Employer has adopted the carryover, the following applies) In lieu of the 2 ½ month grace period, the Health FSA is adding a “Carryover” provision. Under the Carryover provision, up to \$500 of the unused amount for a Plan Year (“Carryover Maximum”) may be rolled over for use in the entire, subsequent Plan Year.

- The specific Carryover amount is generally determined at the end of the run out period following such Plan Year (“Carryover”).
 - For example, if you have an unused Health FSA balance at the end of the 2013 Plan Year equal to \$1000, and you have no other expenses that were incurred in 2013, your 2013

Carryover amount that may be used in the 2014 Plan Year is \$500. However, if you have 2013 Plan Year expenses equal to \$600 that you timely submit during the run out period for the 2013 Plan Year, then your 2013 Carryover amount that may be used in the 2014 Plan Year will only be \$400.

- If you incur an eligible expense during a Plan Year (“Current Year Expense”) but before the end of the prior Plan Year’s run out period, the plan administrator may, at its discretion, apply up to \$500 of the amount unused *at the end of the prior Plan Year* (if any) towards the Current Year Expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during the prior Plan Year (“Prior Year Expenses”) submitted during the prior Plan Year’s run out period and it will reduce the Carryover Maximum by the same amount.
 - For example, assume that you have \$800 at the end of the 2013 Plan year and you have elected \$2500 for the 2014 Plan Year. On February 1, 2014, you incur a \$2700 eligible medical expense. The entire \$2,700 expense will be reimbursed with the \$2,500 elected for 2014 and \$200 of the \$800 unused at the end of the 2013 Plan Year. However, only \$600 will be available for 2013 Plan Year expenses submitted during the run out period for the 2013 Plan year and your 2013 Carryover Maximum is reduced to \$300 (\$500 maximum minus the \$200 already used). Further assume that after reimbursement of the \$2,700 expense that was incurred on February 1, 2014 but before the end of the run out period for the 2013 Plan Year, you submit a \$750 expense incurred in 2013. Only \$600 of that 2013 expense will be reimbursed and you will have no 2013 Carryover for use in the 2014 Plan Year.
- The Carryover does not count against the maximum salary reduction election identified in this Summary Plan Description.
- If you are otherwise eligible for the Health FSA for a Plan Year but you do not make an election to participate, you may still use any Carryover from the prior Plan Year for Current Year Expenses and Prior Year Expenses (in accordance with terms of the Plan and the ordering rules described above).
- Under IRS rules, if you have unused Health FSA amounts on the last day of a Plan Year in a general purpose Health FSA (i.e., anything other than a \$0 balance), you (and your spouse, if you are married) cannot contribute to an HSA during the following plan year. For this purpose, whether you have unused Health FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted). Unless, based on IRS clarification, your employer allows you to waive any Carryover eligibility and/or direct such amounts to a limited purpose Health FSA (if offered) you must exhaust your general purpose Health FSA account prior to the last day of the Plan Year to retain HSA eligibility.
- You must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

V. CLAIMS AND APPEAL PROCEDURES

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably

possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision.

Each participant has the right to request and obtain documents, records and other information as it pertains to the Plan.