GENE B GLICK COMPANY INC
INDIANAPOLIS IN

Flexible Spending Summary Plan Description
7670-03-410719

Revised 08-01-2018

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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GENE B GLICK COMPANY INC

FLEXIBLE SPENDING PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You with summary information on benefits available under this Plan as well as with information on Your rights and obligations under Your employer's sponsored Flexible Spending Plan (also known as a Cafeteria Plan). You are a valued Employee of GENE B GLICK COMPANY INC, and Your employer is pleased to provide You with benefits that can help meet Your health care and Dependent care needs. Please read this document carefully and contact Your human resources or personnel office if You have questions. This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document. It is being furnished to You in accordance with ERISA.

The Plan is intended to qualify as a "cafeteria plan" under Code §125. The purpose of the cafeteria plan is to allow Employees to choose between two or more benefits consisting of cash and certain qualified benefits, namely coverage under a variety of benefit plans sponsored by Your employer.

The cafeteria plan offers You flexible spending account choices as well as other benefit options. Benefit options offered under the cafeteria plan are separate plans for purposes of administration and legal compliance.

- Health Care Spending Account (Health FSA)
- Dependent Care Spending Account
- Medical Benefits Plan
- Dental Plan
- Vision Plan
- Group Term Life
- Short Term Disability
- Long Term Disability
- AD&D

GENE B GLICK COMPANY INC is named the Plan Administrator for purposes of this Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and perform other administrative duties for the Plan. As the Third Party Administrator, UMR does not assume liability for benefits payable under this Plan, as it is solely the claims paying agent for the Plan Administrator.

Your employer assumes the sole responsibility for funding the Employee benefits out of its general assets; however, Employees cover most of the costs with pre-tax contributions from their payroll. All claim payments and reimbursements are paid out of the general assets of the employer and there is no trust or other separate fund from which benefits are paid.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), and the procedures to be followed in making claims for benefits and appeals of denied claims are outlined in the following pages of this SPD.

Some of the terms used in this SPD begin with a capital letter. These terms have special meaning under the Plan and are listed in the Glossary of Terms. When reading the provisions of this SPD, You should refer to the Glossary of Terms. Becoming familiar with the terms used and defined will give You a better understanding of the procedures and benefits described in this SPD.

Please read this SPD carefully and contact Your Human Resources department if You have questions.

This SPD becomes effective on August 1, 2010.

PLAN INFORMATION

Plan Name	GENE B GLICK COMPANY INC FLEXIBLE SPENDING PLAN
Name and Address of Employer	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240
Name, Address and Phone Number of Plan Administrator	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240 317-469-5867
Named Fiduciary	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240
Employer Identification Number Assigned by the IRS	35-0924178
Plan Number Assigned for the Health Care Spending Account	501
Type of Benefit Plan Provided	Self-Funded Medical Reimbursement Plan under Code §105(b) and Dependent Care Assistance Plan under Code §129.
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the employer's Flexible Spending Plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments and enrollment.
Name and Address of Agent for Service of Legal Process	GENE B GLICK COMPANY INC 8801 RIVER CROSSING BLVD STE 200 INDIANAPOLIS IN 46240
Funding of the Plan	Employee Contributions Benefits are provided under a benefit plan maintained on a self-insured basis by Your employer.
Plan Year	Begins on August 1 and ends on the following July 31.
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this SPD and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this SPD shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator, and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of this SPD or any other written instrument and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain administrative responsibilities to the Third Party Administrator for this Plan. Unless otherwise provided for in the service agreement, all obligations under this Plan remain the responsibility of the Plan Administrator. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator shall be afforded deference and subject to review by a legal authority only to the extent that it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrator shall be based only on such evidence presented to, or considered by, the Plan Administrator or the Third Party Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan means that You consent to the limited standard and scope of review afforded under law.

CAFETERIA PLAN HIGHLIGHTS

The GENE B GLICK COMPANY INC's Cafeteria Plan allows its Employees to use pre-tax dollars to pay for their portion of the necessary contributions on a Salary Reduction basis for the component benefits offered under the Cafeteria Plan.

The following benefits and accounts are offered under this Cafeteria Plan:

- Health Care Spending Account (Health FSA)
- Dependent Care Spending Account
- Medical Benefits Plan
- HRA
- Dental Plan
- Vision Plan
- Group Term Life
- Short Term Disability
- Long Term Disability
- AD&D

PARTICIPATION IN A COMPONENT BENEFIT PLAN(S) / ACCOUNT(S)

In order to participate in a specific component benefit offered under this Cafeteria Plan, You must elect that component benefit on forms provided by the Plan Administrator and will be required to share the cost of the component benefit as provided below. Further, You must meet any eligibility, participation, or other requirements applicable to that component benefit plan or account.

EMPLOYEE CONTRIBUTIONS

Other than for the Health Care and Dependent Care Spending Account, Your contribution amount for the component benefits offered under this Cafeteria Plan will be established by the Plan Administrator in its sole discretion.

PAYING THE CONTRIBUTIONS FOR THE APPLICABLE BENEFIT PLAN(S) / ACCOUNT(S)

As an Employee, You have the option under this Cafeteria Plan to either pay the applicable contribution amount on a pre-tax Salary Reduction basis, or to pay the applicable contribution amount with after-tax dollars outside of this Cafeteria Plan. Your election will be irrevocable for the entire Plan Year, unless You experience a Change In Status Event (see below) that would permit an election change or some other regulatory exception applies. Please see Your Human Resource representative if You have any questions.

USE-OR-LOSE RULE

Plan Your Health Care and/or Dependent Care elections carefully. Any unused benefits or contributions in Your health or dependent care account will be forfeited if they are not used to pay or reimburse expenses that You or Your Dependents (if applicable) Incur by the end of the Plan Year with the exception of a Qualified Reservist Distribution or a permitted health care FSA carryover amount as stated elsewhere within this document. Forfeited amounts will be used to offset reasonable administrative expenses and future costs of the applicable benefit plan. Refer to the Plan's timely filing provision for details regarding the deadline for submitting claims.

If You are a Qualified Reservist called to active duty, You may request that the amount of pre-tax Salary Reductions withheld as of the date You are called to active duty, minus any prior reimbursements, be distributed to You through Your paycheck. The distribution will be added to Your gross income and be subject to tax. Refer to the Health Care Spending Account provision for further details for requesting a Qualified Reservist Distribution.

BENEFITS WILL BE PROVIDED BY THE APPLICABLE BENEFIT PLAN(S) / ACCOUNT(S)

The applicable benefit plan / account that You are a participant in will provide You with the benefits that You may be entitled to under that plan or account. Information regarding those benefit plans / accounts will be explained in a separate section of this SPD. (See Table of Contents).

ELIGIBILITY AND ENROLLMENT
(Participating in the Plan)

ELIGIBILITY REQUIREMENTS

You are eligible to participate in the Plan if You meet the requirements stated below:

Eligible Employee

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works 30 or more hours per week (the Plan will grandfather those employees who are working between 20 and 30 hours prior to 08-01-2013), is a member of the Board of Directors or the Chairman of the Board Emeritus, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees, including the following (applies to the Health Care and Dependent Care Spending Account(s) only):
  - An Independent Contractor as defined in this Plan.
  - A consultant who is paid on other than a regular wage or salary by the employer.

For purposes of this Plan, eligibility requirements are used only to determine an Employee's initial eligibility for coverage under this Plan. An Employee will retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy. The employer's classification of an Employee is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of an Employee's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

EFFECTIVE DATE / ENROLLMENT

New Employees

If You are a new Employee, You will first become eligible to participate in the Plan on Your Employment Commencement Date, provided that You meet the eligibility requirements as stated above. You must enroll by submitting an online election to the Plan Administrator within 31 days from Your Employment Commencement Date. Your coverage under the Plan will become effective on the first day of the month following one month of employment. If You do not submit the online election within the specified time frame, You will not become enrolled in the Plan for the current Plan Year and You may not elect to participate in the Plan until the next annual open enrollment period unless otherwise stated in this SPD. Your contributions will be deducted from Your paycheck beginning with the first pay period You are enrolled.

Important: If You do not elect to participate when first eligible, You may not enroll in the Plan until the next annual open enrollment period as described below.

Existing Employees

If You are an existing Employee who wishes to continue or begin to participate (for those Employees who did not elect when first eligible) in the Plan, You must elect to do so during the annual open enrollment period. Each year during the annual open enrollment period, You will be provided with an opportunity to elect to participate in the Plan or choose not to participate.

An online election will be available to You. The election form enables You to elect to participate in the Plan and to authorize the necessary Salary Reductions to pay for the benefits elected. The online election must be submitted to the Plan Administrator on or before the last day of the annual open enrollment period. If You are an eligible Employee and fail to submit the online election within the specified time frame, You will not be able to elect to participate in the Plan until the next annual open enrollment period.

ANNUAL OPEN ENROLLMENT PERIOD

If You are an eligible Employee who previously waived coverage under this Plan, including the Health Care and Dependent Care Spending Accounts, You may apply for coverage during the annual open enrollment period in the form and manner prescribed by the employer. Similarly, if You wish to change Your benefit election(s) under Your Health Care or Dependent Care Spending Account(s), You may request the change during the annual open enrollment period as well.

The annual open enrollment period shall typically be held in June. The employer will provide You with a written notice prior to the start of an annual open enrollment period. The Effective Date of coverage shall be August 1 following the annual open enrollment period.

Participation does not carry over into the following Plan Year. You must re-enroll each year to be effective August 1. Your choice will be effective during the Plan Year following open enrollment for as long as You are eligible.

Your contributions will be deducted from Your paycheck beginning with the first pay period You are enrolled or the first pay period of the new Plan Year if You enroll during open enrollment.

TERMINATION OF PARTICIPATION

You will cease to be a Participant in the Plan upon the earlier of:

- The expiration of the Plan Year for which You have elected to participate (unless during the annual open enrollment period for the next Plan Year You elect to continue participating);
- The termination of the Plan;
- The date on which You cease (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an eligible Employee; or
- The date You revoke Your election to participate under a circumstance when such change is permitted under the terms of the Plan.

When You cease to be a Participant in the Plan, Your Salary Reductions will terminate under the Cafeteria Plan, as will Your ability to receive reimbursements from Your FSA(s) for expenses Incurred after Your termination, unless otherwise stated within this SPD. For Health Care Spending Accounts, You may elect to continue Your coverage under COBRA. For more detail, refer to Reimbursements after Termination within this SPD.

However, for Your Health Care and Dependent Care Spending Accounts, You (or Your estate) may claim reimbursement for any eligible expenses Incurred during the Period of Coverage prior to termination, provided You (or Your estate) file a claim within 92 days following the close of the Plan Year in which the expense arose or 90 days following termination.

CHANGE IN STATUS
(Permitted Election Changes)

The IRS irrevocability rule generally prohibits changes to Your election mid-year. However, there are exceptions to this general rule. Because Your contribution is deducted from Your paycheck, on a pre-tax basis, the Code regulates when You may enroll, cancel or make changes to that election. Therefore, unless You have a "Change in Status" as described in this SPD, You may not enroll or revoke an election until the next annual open enrollment period.

The change You make must be consistent with the Change in Status rules. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. The general rule is that a desired election change will be found to be consistent with a Change in Status if the event affects coverage eligibility.

Unless otherwise stated in this SPD, changes to an election must be made within 31 days following the Change in Status event and will become effective the following pay period after You make the election.

The events 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. Determinations will be on a uniform and consistent basis in accordance with IRS or other applicable regulations and other terms and conditions contained in this SPD.

Unless specifically stated otherwise below, the following permitted events shall apply to the component benefit plans offered under this Cafeteria Plan.

CHANGE IN STATUS INCLUDING: LEGAL MARITAL STATUS, NUMBER OF DEPENDENTS, AND DEPENDENT SATISFYING OR CEASING TO SATISFY AS A DEPENDENT

You may revoke an election for the Plan Year and make a new election if You experience any of the following Change in Status events: an event that changes Your marital status (marriage, divorce, annulment or legal separation from a Spouse, the death of a Spouse), an event that changes the number of Your Dependents (the death of a Dependent, birth, adoption, and Placement for Adoption), or an event that causes Your Dependent to begin to satisfy or cease to satisfy the eligibility requirements for coverage. You may only elect to change an election for the affected person that corresponds with the permitted event. For example:

- the Spouse involved in the divorce, annulment, or legal separation;
- the deceased Spouse or Dependent;
- the Dependent that ceased to satisfy the eligibility requirements; or
- the Dependent that begins to satisfy the eligibility requirements.

Adding or canceling coverage for any other individual that is not affected by the permitted event would fail to correspond with that Change in Status. Notwithstanding the forgoing, if You or Your Dependent(s) become eligible for COBRA (or similar health plan continuation coverage under state law) under the employer's plan, You may increase Your Salary Reduction election under the Cafeteria Plan to pay for such coverage (this rule does not apply to a Spouse who becomes eligible for COBRA or similar coverage as a result of divorce).

HIPAA SPECIAL ENROLLMENT RIGHTS (Does not apply to the Health Care or Dependent Care Spending Accounts)

If You and/or Your Dependents acquire special enrollment rights under HIPAA for one of the component benefit plans offered under this Plan, You may revoke Your prior election for group health plan coverage for the Plan Year as well as Your Salary Reduction amount and make a new election that corresponds with such enrollment rights, regardless of whether the HIPAA special enrollment also qualifies as a Change in Status. As required by HIPAA, a special enrollment right will arise if:

- You or Your Dependent(s) declined to enroll in group health plan coverage because You or Your Dependent(s) had other coverage and subsequently eligibility for such other coverage is lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

- You and/or Your Dependent(s) were covered under a Medicaid plan or state child health plan and Your or Your Dependent(s) coverage was terminated due to loss of eligibility. In this instance, You must request coverage for the component benefit plan offered by Your employer under this Flexible Spending Plan within 60 days after the date of termination of such coverage; or

- You acquire a new Dependent as a result of:

  - marriage,
  - birth,
  - adoption, or
  - Placement for Adoption.

  If You acquire a new Dependent as a result of birth, adoption, or Placement for Adoption, You may enroll the newly acquired Dependent, as well as Yourself and Your Spouse if You and Your Spouse are not already enrolled in the component benefit plan. In the event of marriage, You may enroll Yourself and Your newly acquired Spouse.

  Election changes (including Your Salary Reduction election) made on account of a birth, adoption, or Placement for Adoption will be effective retroactively to the date of the event. However, election changes (including Your Salary Reduction election) attributable to marriage, will be effective on the first day of the month following the receipt of the Your election form by the Plan Administrator.

- You and/or Your Dependent(s) may be eligible for a Special Enrollment period if You and/or Your Dependent(s) are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under a component benefit plan offered by Your employer under this Flexible Spending Plan. You must request coverage for the component benefit plan offered under this Flexible Spending Plan within 60 days after the date You and/or Your Dependent(s) are determined to be eligible for such assistance.

COURT JUDGMENTS, DECREES AND ORDERS (Does not apply to the Dependent Care Spending Account)

If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires that a Plan provided for under this Cafeteria Plan provide medical coverage for a Dependent child, You may:

- change Your election to provide coverage for the Dependent child (provided that the order requires You to provide coverage), or

- change Your election to revoke coverage for the Dependent child if the Order requires that another individual (including Your Spouse or former Spouse) to provide coverage under that individual's plan and such coverage is actually provided.

CHANGE IN EMPLOYMENT STATUS AND GAIN OF COVERAGE ELIGIBILITY UNDER ANOTHER EMPLOYER'S PLAN

You may revoke an election for the Plan Year and make a new election if You or Your Dependent(s) experience an event that results in a change in the employment status of You, Your Spouse or Dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence. If Your request is to cease or decrease coverage as a result of gaining eligibility for coverage under a Cafeteria Plan or qualified benefit plan of Your employer or a Dependent's employer, the Plan Administrator may rely on Your certification that You or Your Dependent(s) have obtained or will obtain coverage under another plan, unless the Plan Administrator has reason to believe that Your certification is incorrect.

CHANGE IN COST (Does not apply to the Health Care Spending Account)

For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, a health care spending account (health FSA) is not similar coverage with respect to an accident or health plan that is not a health FSA. This Plan treats coverage by another employer, such as a Dependent's employer, as similar coverage.

- *Increase or Decrease for Insignificant Cost Changes*. You are required to increase Your elective contributions (by increasing Salary Reductions) to reflect insignificant increases in required contribution for a benefit package option(s), and to decrease Your elective contributions to reflect an insignificant decrease in their required contribution. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective contributions on a prospective basis.

- *Significant Cost Increases*. If the Plan Administrator determines that the cost charged to You for a benefit package option significantly increases during a Period of Coverage, You may

  - Make a corresponding prospective increase to Your elective contributions (by increasing Salary Reductions);

  - Revoke Your election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another benefit package option offered by the employer that provides similar coverage; or

  - Drop coverage prospectively if there is no other benefit package option available that provides similar coverage. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant.

- *Significant Cost Decreases*. If the Plan Administrator determines that the cost of any benefit package option significantly decreases during a Period of Coverage, the Plan Administrator may permit the following election changes:

  - If You are enrolled in a benefit package option other than the benefit package option that has decreased in cost, You may change Your election on a prospective basis to elect the benefit package option that has decreased in cost; and/or

  - If You are otherwise eligible, You may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost decrease is significant.

FMLA LEAVE (Does not apply to the Dependent Care Spending Account)

If You are on an unpaid leave of absence under the FMLA, You may revoke an existing election for the remaining portion of the Plan Year and make a new election upon returning from such leave, even if coverage terminated during such leave due to the nonpayment of any required contributions. You may also enroll in the Plan or change an election while You are on leave in the same manner as an active Employee.

MEDICARE AND MEDICAID (Does not apply to the Dependent Care Spending Account)

If You are a Participant in this Plan, and You become enrolled in Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), or lose such coverage, You may revoke an election under this Plan and make a new election consistent with Your eligibility for Medicare or Medicaid.

YOUR FLEXIBLE SPENDING ACCOUNT(S)

If You decide to participate in one or both accounts (Health and Dependent Care), You must select the amount(s) You would like to contribute on a pre-tax basis. Both the Health Care Spending Account and the Dependent Care Spending Account are a source of pre-tax funds to reimburse Yourself for Covered Expenses. An account will be set up in Your name to keep a record of the reimbursements to which You are entitled. These accounts are record keeping accounts; they are not funded (all reimbursements are paid out of the general assets of Your employer.) Your employer is currently bearing the entire cost of administering these accounts, except for amounts forfeited that may be applied to administrative expenses.

CONTRIBUTION MAXIMUMS / MINIMUMS

Account type	Contribution maximum	Contribution minimum
• Health Care Spending Account	$2,650 per Plan Year	$5 per Plan Year
• Dependent Care Spending Account	$5,000 per Taxable Year (See Dependent Care Provision for further details)	$5 per pay period

TAX ADVANTAGES

Flexible Spending Accounts (FSA) allow You to pay for Covered Expenses with contributions drawn from Your Compensation before taxes are withheld. These contributions generally are not subject to:

- Federal income tax.
- Social Security and Medicare tax.
- State income taxes (in most cases).

The income set aside in an FSA reduces Your taxable income. That means Your pre-tax dollars can be stretched further when spent on Covered Expenses than would otherwise be possible with after-tax dollars. This can be of significant value for You and Your family. Your FSA provides a tax savings up-front, as opposed to an after the fact deduction on Your tax return.

For example, if You set aside $50 a month in an FSA, You would have $600 ($50 x 12 months) to spend on Covered Expenses. Without this account, You would have to earn approximately $900 in pre-tax dollars to pay for $600 in expenses. The cost of these qualified expenses is the same whether paid with before-tax or after-tax dollars, but with an FSA Your dollars go further because FSA contributions, are made on a pre-tax basis.

Please note that You may seek tax benefits on Covered Expenses through Your income tax returns if You do not receive tax benefits through an FSA. Please consult Your tax consultant for advice on Your particular situation. For general guidance, refer to *IRS Publication 502* (for Medical Care Expense detail) and *IRS Publication 503* (for Dependent Care Expense detail).

Note: These publications are written by the IRS solely for the purpose of income tax guidance and so may not necessarily constitute eligible expenses under an FSA governed by Code. Further, for reimbursement under Your Health Care or Dependent Care Spending Account(s), You must refer to this SPD to determine what constitutes a Covered Expense.

USING YOUR ACCOUNT

If You elect to participate in either or both the Health Care and Dependent Care FSA, You must follow a few general rules that govern their use:

- Funds may not be transferred from one FSA to another.
- Funds may only be used for Covered Expenses, as determined by the claims administrator.
- Funds in excess of the health care FSA carryover amount not used to pay for Covered Expenses Incurred during the applicable coverage period will be forfeited at the end of the year.

IRREVOCABILITY OF YOUR ANNUAL ELECTIONS

Before You decide how much to deposit, carefully estimate Your Medical Care and Dependent Care Expenses for the year. Since the amount reimbursed to You from Your account is not subject to taxes, the IRS places certain restrictions on Your deposits:

- Once You have made Your election to contribute to Your account, You cannot change the amount of money You contribute until the beginning of the next Plan Year, with the exception for a Qualified Reservist Distribution. Refer to the Health Care Spending Account provision for further details.
- Any money that You do not claim for expenses Incurred during the Plan Year through the use of carryover will be forfeited, with the exception for a Qualified Reservist Distribution. Refer to the Health Care Spending Account provision for further details. These forfeitures are used to offset the administrative expenses of the Plan.

DUPLICATE REIMBURSEMENTS NOT ALLOWED

If You submit a claim to Your Health Care or Dependent Care Spending Account, You may not claim the same expense as a deduction on Your income tax return. If You receive a reimbursement from a third party for expenses already reimbursed by one of Your Flexible Spending Accounts, You will be required to reimburse the Plan for the benefits received.

HEALTH CARE SPENDING ACCOUNT

The Health Care Spending Account (Health FSA) is provided to allow You, as a Participant, to receive benefits in the form of reimbursement for Medical Care Expenses that are intended to be eligible for exclusion from gross income under Code §105(b).

ACCOUNT MINIMUMS

The minimum annual contribution is $5.

ACCOUNT MAXIMUM

You can contribute up to $2,650.

If You and Your Spouse both work for GENE B GLICK COMPANY INC, You may each contribute $2,650 to separate accounts. You may claim eligible expenses for each covered Dependent once.

If You are hired mid-year, the account maximum will be prorated. The account maximum shall be prorated on the basis of monthly contributions. The remaining full months in the Plan Year multiplied by the maximum contribution per month. For example, if $2,650 is the annual maximum, and You are hired in the middle of October, the total available beginning in November would be approximately $102 per pay period multiplied by the number of pay periods remaining in the Plan Year. (Example calculated on a bi-weekly pay schedule.)

UNIFORM COVERAGE

You have immediate access to the total amount of Your annual contribution on the first day of the Plan Year. The uniform coverage rule provides that Your entire annual election may be reimbursed to You for qualified Medical Care Expenses, regardless of the amount actually in Your account at the time.

TAX CONSIDERATIONS

The amount You allocate to this account may be used to reimburse You for any Medical Care Expenses that ordinarily would qualify as a medical deduction for federal income tax purposes. However, if You participate in this account, You cannot claim any Medical Care Expenses that are reimbursed through this account as a deduction on Your federal income tax return since Your taxable income already has been reduced.

If You have any questions or need any assistance, contact Your Human Resources representative or Your personal tax advisor.

HEALTH CARE FSA CARRYOVER

If You were enrolled in the Health Care Spending Account as of the end of the prior Plan Year, and You are still eligible for the Plan, You may be able to carry over up to $500 from the prior Plan Year to be used in the current Plan Year. The carryover allows You and Your Dependents (if applicable) to use these dollars for those expenses Incurred at any point within the new Plan Year.

QUALIFIED RESERVIST DISTRIBUTION

In accordance with the "Heroes Earning Assistance and Relief Tax Act of 2008" ("HEART Act") a qualified distribution is permitted of the amount of pre-tax Salary Reductions withheld as of the date You are called to active duty, minus any prior reimbursements, if You are a reservist called to active duty when:

- the reservist is called up for a period of over 179 days or for an indefinite period of time, and
- the distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the Health Care Spending Account for the Plan Year.

To receive a qualified distribution of the amount of pre-tax Salary Reductions withheld as of the date You are called to active duty; minus any prior reimbursements You must give notice to Your employer by contacting Your Human Resources Department as soon as You receive Your orders or are called to active duty and request a qualified distribution. Your employer will notify the Plan Administrator (if other than the employer) of the request for a qualified distribution.

Once Your Plan Administrator has determined Your eligibility for a qualified distribution, You will see Your qualified distribution as part of Your paycheck, subject to taxation.

In the event that the IRS issues further guidance regarding Qualified Reservist Distributions, this provision will be administered accordingly to that guidance.

You should call the Plan Administrator if You have questions about Your rights to receive a Qualified Reservist Distribution under the ("HEART Act") and applicable regulations.

MEDICAL CARE EXPENSES

The Internal Revenue Service (IRS) determines what qualifies as a Medical Care Expense. If not specifically excluded, IRS qualified Medical Care Expenses under Code §213 are covered by this Plan.

Medical Care Expenses must have been Incurred during the Plan Year. With the exception for orthodontia expenses, a Medical Care Expense is Incurred when the service that gives rise to the expense is provided, or Incurred. When the expense is billed, charged or paid is irrelevant.

Orthodontia expenses may be reimbursed by this Plan if the expense has been Incurred within the Period of Coverage. This includes orthodontia expenses that are paid in advance of the services being provided if the advance payment is required in order to receive the service (i.e., down payment). Your orthodontia expenses will be deemed to have been Incurred when You make the advance payment, provided that the payment is made within the Period of Coverage.

Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by Your dentist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided, and subsequent proportional payments in anticipation of follow-up services.

You may not be reimbursed for any expenses arising before the Plan becomes effective, before Your Salary Reduction agreement becomes effective, for any expenses Incurred after the close of the Plan Year, or after a separation from service (except for continuation coverage).

Medical Care Expenses Includes Expenses on Behalf of Dependents. Medical Care Expenses includes expenses Incurred by Your Spouse or Your Dependent (See Glossary of Terms) provided that the Spouse or Dependent is:

- Your Spouse so long as he or she is not covered as an Employee under this Plan. When a person is no longer Your Spouse that person no longer qualifies as Your Dependent.

- Your child until the end of the taxable year in which he or she reaches his or her 26th birthday.

- If You have a Dependent child covered under this Plan who is mentally or physically disabled, that child's health coverage may continue beyond the day the child would cease to be a Dependent under the terms of this Plan as shown in the definition of Dependent. You must submit proof that the child meets these conditions within 31 days after the day coverage would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage will continue for as long as he or she:

  - Is dependent on You and Your Spouse for more than half of his or her support;

  - Is not able to hold a self-sustaining job due to the mental or physical disability; and

  - Has submitted required proof as described above.

MEDICAL VS. PERSONAL EXPENSE

Expenses Incurred for personal reasons only are not reimbursable, according to the IRS. Claims that have been Incurred for medical reasons, but which could also have been for personal reasons, are more closely scrutinized by the IRS than those claims that are obviously for medical reasons only. Massage Therapy is an example of such an expense, where there could be a medical reason for the massage therapy, but also a personal reason for the therapy. Therefore, in cases where there could be both a medical and a personal reason for the expense, the Plan may require additional substantiation for these claims to establish the link between the medical condition (necessity) and the expense.

Some of the most common Medical Care Expenses that qualify for reimbursement so long as they are not reimbursable from any other source include:

- Cost sharing on health care coverage such as deductibles, co-payments or any other participation in medical expenses.
- Qualified expenses beyond Plan limits.
- Qualified expenses not covered by the Plan.

Expenses: Here are some examples of Medical Care Expenses:

- Medicine or Medication.
- Medical or dental care outside Plan scope.
- Vision care outside Plan scope, including prescription eye glasses and contact lenses.
- Hearing aids.
- Medical Care Expenses that have not been reimbursed and are not reimbursable from any other source for a Dependent who is claimed for federal income tax return purposes on Your income tax return.
- Shipping, handling and sales tax of eligible expenses.

ELIGIBLE MEDICAL CARE EXPENSES UNDER CERTAIN CONDITIONS (These expenses require additional substantiation)

- Herbal remedies to treat a specific condition or disease.
- Weight loss drugs or programs to treat a specific condition or disease (including obesity) diagnosed by a Physician.
- Long-term care services or nursing home services (qualified).
- Capital expenses.
- Household improvements to treat allergies.
- DNA collection and storage.
- House improvements (i.e., exit ramps, widening doorways).
- Mattress, recliner chairs and other furniture.
- Special foods needed to treat a special Illness or ailment, if prescribed by a Physician and does not substitute normal nutritional requirements.

PLAN EXCLUSIONS

The following items are not considered a Medical Care Expense under the IRS Code and/or for purposes of this Plan:

- Drugs obtained in an illegal way.
- Controlled substances if the substance violates federal law, even if prescribed by a Physician.
- Vitamins or dietary nutritional supplements available without prescription, even if prescribed by a Physician.
- Health insurance premiums that You or Your Spouse pay for coverage under another health plan.
- Insurance premiums generally.
- Cosmetic Surgery or other similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified Physician due to Your or Your Dependent's inability to perform physical housework).
- Custodial care.
- Massage therapy unless prescribed by a Physician to treat a specific injury or trauma.
- Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- Health club dues with respect to general membership.
- Weight loss drugs or programs unless for a specified disease diagnosed by a Physician such as: obesity, heart disease, or diabetes.
- Social activities, such as dance lessons, even if recommended by a qualified Physician for general health improvement.
- Swimming lessons, even if recommended by a Physician for general health.
- Maternity clothes.
- Diaper service or diapers.
- Uniforms or special clothing, such as maternity clothing.
- Transportation expenses not primarily for and essential to medical care.
- Home or automobile improvements or other similar capital expenses to the extent that they appreciate value of personal assets.
- Any expense that does not qualify under Code §213.
- Teeth bleaching.
- Exercise equipment or programs unless prescribed by a Physician to treat a specific medical condition.

OVER-THE-COUNTER DRUGS/ITEMS

ELIGIBLE OVER-THE-COUNTER (OTC) DRUGS

Eligible OTC drugs include Medicines that alleviate or treat injuries or sicknesses and that are prescribed by a Physician. They are not cosmetic in nature nor merely beneficial to a Covered Person's general health. They include such items as antacids, allergy Medicines, pain relievers, cold Medicines, and other qualified Code §213 Medical Care Expenses.

ELIGIBLE OVER-THE-COUNTER (OTC) ITEMS

Eligible OTC items include any items that alleviate or treat injuries or sicknesses. They are not cosmetic in nature nor merely beneficial to a Covered Person's general health.

INELIGIBLE OVER-THE-COUNTER (OTC) DRUGS

Ineligible OTC drugs/items that are merely beneficial to general health are ineligible, including toiletries, Cosmetics, and vitamins or dietary supplements are not reimbursable under the Plan, as well as other Medical Care Expenses that are not qualified under Code §213.

DUAL-PURPOSE OVER-THE-COUNTER (OTC) DRUGS/ITEMS

Some OTC drugs/items have a medical purpose *and* a cosmetic or general health purpose. These items are referred to as "dual- purpose" drugs/items. Requests for reimbursement of dual-purpose expenses require a Physician's diagnosis of a medical condition, and a signed statement by a Physician. For dual purpose OTC drugs, You will need a prescription.

IMPORTANT INFORMATION ABOUT THE ABOVE EXPLANATIONS

Eligible OTC expenses shall be determined consistent with IRS Code §213, the Healthcare Reform Act of 2010, and interpreted by the Plan Administrator in its discretion. Discretionary authority of the Plan Administrator is described in this SPD in the Plan Information and the Recordkeeping and Administration provisions.

LIMITATIONS ON REIMBURSEMENT OF OVER-THE-COUNTER DRUGS/ITEMS

You will only be reimbursed for a reasonable quantity of an eligible Over-the-Counter Medical Care Expense as determined by the Plan Administrator under the Plan (i.e., 25 bottles of aspirin in one month would not be reasonable).

SUBMITTING CLAIMS FOR OVER-THE-COUNTER DRUGS/ITEMS

You must submit a signed claim form along with the receipt for all claims. For OTC drugs You will need to also provide a prescription or a prescription number. The receipt for any Over-the-Counter Drugs/Items must include the following information:

- Merchant name
- Description of the Over-the-Counter Drugs/Items
- Date purchased
- Amount paid
- Prescription/prescription number for OTC drugs (for an off-the-shelf drug You will also need to include the quantity prescribed, the instructions, and the signature of the provider who prescribed the drug).

Reminder: any claim that You submit must be for You or an eligible Dependent. Any attempt to submit unqualified claims constitutes fraud. Fraud by a Participant is described in this SPD in the Fraud Provision.

CLAIMS AND APPEAL PROCEDURES FOR HEALTH CARE SPENDING ACCOUNTS (Health FSA)

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the applicable legal requirements. The Plan provisions will be applied consistently with respect to similarly situated individuals.

TIMELY FILING

All claims must be submitted for reimbursement 92 days after the end of the Plan Year or 90 days following termination to recoup Your contributions to Your Health Care Spending Account, or You will forfeit any amount in excess of the Health Care FSA carryover amount remaining in Your account. See the prior discussion of the "use-or-lose rule."

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

In general, if You choose to use a Personal Representative, You must submit proper documentation the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, You must agree to grant Your Personal Representative access to Your Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Participant to be effective. When Health FSA claims are submitted to the Plan by a Personal Representative, it will be assumed that the Personal Representative is acting as the Personal Representative of the Participant.

PROCEDURES FOR SUBMITTING CLAIMS

Claims may be submitted as Covered Expenses are Incurred during the Plan Year. Your Plan Year is the 12-month period beginning on August 1. You will be reimbursed for eligible Flexible Spending Account expenses as long as the amount requested is at least $10 and the amount does not exceed the limit of Your contributions for the year, including any prior withdrawals and any availability restrictions. The $10 minimum claim requirement will be waived at the end of each month to assure that You receive the tax benefit of all Covered Expenses, up to Your contribution limit for the year.

If You or Your Dependent receive services in a country other than the United States, You will be reimbursed for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date of service.

To have Your claims processed as soon as possible, please read the claim instructions found on the Flexible Spending Account Claims Form.

SUBMITTING HEALTH CARE CLAIMS

Under this Plan, You have three options for seeking reimbursement for Your Medical Care Expenses. You can submit the claim either on an FSA claim form or by submitting the claim information through the UMR website on an FSA claim form as described below, or You can seek reimbursement by using Your debit card. The following is a summary of the options described above.

If You have health care expenses not submitted on a medical or dental plan claim that is processed through UMR, You will need to fill out an FSA claim form or submit Your claim information through the UMR website.

Flexible Spending Accounts Claim Forms are available at www.UMR.com, in Your Human Resources department, or by calling the toll-free number: 1-800-826-9781. You must submit a claim form for each claim You submit.

Whether You submit Your claim on an FSA claim form or via the UMR website, You must include the following information when You submit a medical expense:

- A written statement or bill from an independent third party.
  - A statement, bill, or receipt from a medical professional (i.e. physician, pharmacist) or Merchant.
  - Or an Explanation of Benefits (EOB)
- The amount of the medical expense.
- An identification or description of the medical expense, minus the amount reimbursable from any other source, if applicable.
- The date that the medical expense was Incurred.
- Prescription / prescription number for OTC drugs (for off-the-shelf drugs You will need to also include the quantity prescribed, the instructions, and the signature of the provider who prescribed the drug.)

Please note that it is not necessary that You have actually paid an amount due for a Covered Expense — only that You have Incurred the expense. You must also attest to the fact that this expense is not being paid for or reimbursed from any other source. Claim forms and the UMR website will contain this detail.

If You have paid the contributions for the coverage You have elected, You will be reimbursed for Your Covered Expenses within 30 calendar days after You submitted Your claim. You will have 92 days after the end of the Plan Year (July 31st) or 90 days following termination in which to submit a claim for reimbursement for Covered Expenses Incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

Debit Card

The debit value card provides You with an automatic way to pay for Your qualified Medical Care Expenses. You may electronically access the pre-tax contributions You set aside in Your Health FSA. Each time You Incur a qualified Medical Care Expense at a health care location that accepts MasterCard®, You may use Your debit card. The amount of Your qualified purchases will be deducted from Your Health FSA automatically.

Do not use Your debit card at locations that are not health-related, such as restaurants, gas stations and bookstores. In addition, You may not use Your debit card to purchase OTC drugs. It is important for You to save itemized receipts whenever You use the card. The IRS requires that all card transactions, except for co-pay matching, recurring expenses, and real-time substantiation, be substantiated by the Plan. Therefore, be prepared to submit Your receipts as proof of eligibility for each transaction. In other words, be certain the transaction is for a Medical Care Expense.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted, You will receive a written Explanation of Benefits (EOB) form that will explain how much was paid towards the claim, or whether the claim was denied. If You have any questions or concerns about the EOB, call UMR at the number listed on the EOB.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

The Plan will process Your claims within 30 calendar days, but the Plan can have an additional 15-day extension when necessary for reasons beyond control of the Plan if written notice is provided to You within the original 30-day period.

A claim is considered to be filed when the claim for benefits has been submitted to the Plan for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- You or Your Dependents are no longer eligible for coverage under the Plan.
- Charges were Incurred prior to Your Effective Date or following termination of coverage.
- You or Your Dependent reached the maximum benefits under the Health FSA.
- Amendment of group flex plan.
- Termination of the group flex plan.
- You did not respond to a request for additional information needed to process the claim or appeal.
- Services are not considered medical in nature.
- Benefit is not covered under this Plan.
- Misuse of the Plan or other fraud.
- Failure to pay required contributions.
- Your claim submission was incomplete.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

An Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that You are no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, You will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefits notice (EOB) will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for You to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or experimental treatment, the Plan will notify You of that fact. You have the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided to You free of charge.

Provide appropriate information as to the steps You can take to submit the claim for appeal (review).

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If You disagree with the denial of a claim, You or Your duly Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below:

First Level of Appeal: This is a **mandatory** appeal level. The Participant must exhaust the following internal procedures before any outside action is taken.

- You must file Your appeal within 180 days of the date You received the EOB form from the Plan showing that Your claim was denied. The Plan will assume that You received the written EOB form seven days after the Plan mailed the EOB form.
- You or Your Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- You may submit written comments, documents, records and other information relating to the claim to explain why You believe the denial should be overturned. This information should be submitted at the time You submit the written request for a review.
- You have the right to submit evidence that Your claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If Your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a medical care professional with training and experience in the relevant medical field. This professional may not have been involved in the original denial decision, nor be supervised by the medical care professional who was involved. If the Plan has obtained medical or vocational experts in connection with Your claim, they will be identified upon Your request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. The notification will provide You with the information outlined under the "Adverse Benefit Determination" section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. You are not required to follow this internal procedure before taking outside action.

- If You are not satisfied with the decision following the first appeal, You have the right to appeal the denial a second time.
- You or Your Personal Representative must submit a written request for a second review within 60 calendar days following the date You received the Plan's decision regarding the first appeal. The Plan will assume that You received the determination letter regarding the first appeal seven days following the date the Plan sent the determination letter.
- You may submit written comments, documents, records and other pertinent information to explain why You believe the denial should be overturned. This information should be submitted at the time You submit the written request for a second review.
- You have the right to submit evidence that Your claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If Your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a medical care professional with training and experience in the relevant medical field. This medical care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the medical care professional who was involved. If the Plan has obtained medical or vocational experts in connection with Your claim, they will be identified upon Your request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. The notification will provide You with the information outlined under the "Adverse Benefit Determination" section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is only available after You have followed the mandatory appeal level as required above. This Plan also agrees that it will not charge You a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if You elect to pursue a claim in court before following this voluntary appeal process. Your decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on Your rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, Your right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on Your additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify You of its decision within the following time frames, although You may voluntarily extend these timelines:

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Within a reasonable period of time but no later than 60 calendar days after the Plan receives Your request for review.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, You have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section for more details. No such action may be filed against the Plan after three years from the date the Plan gives You a final determination on Your appeal.

HEALTH CARE SPENDING ACCOUNT COMPLIANCE WITH ERISA AND LAWS APPLICABLE TO GROUP HEALTH PLANS

LAWS APPLICABLE TO GROUP HEALTH PLANS

Benefits under this Health Care Spending Account shall be provided in compliance with the following laws to the extent that such laws are applicable to the Health FSA and not otherwise exempt:

- Employee Retirement Income Security Act (ERISA);
- Consolidated Omnibus Budget Reconciliation Act (COBRA);
- Family Medical Leave Act (FMLA);
- Uniformed Services Employment and Reemployment Rights Act (USERRA);
- Mental Health Parity Act;
- Newborns' and Mothers' Health Protection Act;
- Women's Health and Cancer Rights Act; and
- Medicare Secondary Payer law, as amended.

COORDINATION OF BENEFITS

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

REIMBURSEMENTS AFTER TERMINATION

When You cease to be a Participant under the Health FSA, Your Salary Reductions will terminate. You will not be able to receive reimbursements under the Health FSA for expenses Incurred after Your participation terminates.

You may, however, be able to elect to continue Your coverage under the continuation of coverage provisions of COBRA, as stated below. In addition, You (or Your estate) may claim reimbursement under the Health FSA for any expenses Incurred during the Period of Coverage prior to termination, provided You (or Your estate) file a claim within 92 days following the close of the Plan Year in which the expenses arose (i.e., generally July 31st) or 90 days following termination.

COBRA (Continuation Coverage for Health Care Spending Account Benefits)

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You and Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a Spouse's plan), even if that plan generally does not accept Late Enrollees.

Continuation coverage refers to Your right, or Your Spouse's or Dependents' right, to continue the same coverage under the health FSA that was in place the day before a Qualifying Event if participation by You (including Your Spouse and Dependents) otherwise would end due to the occurrence of the Qualifying Event.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including health care spending account benefits) beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active Participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered Spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

A **Qualifying Event** is:

- Termination of Your employment (other than by reason of gross misconduct) or reduction of Your work hours;
- Your death;
- Divorce or legal separation from Your Spouse;
- Your becoming entitled to receive Medicare benefits; or
- Your Dependent no longer qualifying as a Dependent.

A **Qualified Beneficiary** is a person covered by the health FSA the day before the Qualifying Event who is:

- The Employee; or
- The Spouse of a covered Employee; or
- The Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE HEALTH CARE FLEXIBLE SPENDING COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that he or she must complete in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

ELIGIBILITY FOR COBRA

Only those Participants with positive health FSA balances will be eligible for COBRA continuation coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the health FSA will cease at the end of the year and will not be continued for the next Plan Year. You will pay premiums for such coverage on an after-tax basis, but not beyond the current Plan Year.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, health care flexible spending coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes the waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

You will be required to pay the entire cost of continuation coverage. The cost of Your coverage under the health FSA will be based on the balance of Your health FSA and the number of months remaining in the Plan Year. This cost may also include a 2% additional fee to cover administrative expenses.

The initial payment is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time Your coverage under the health FSA would have otherwise terminated, up to the time You make Your first payment. If the initial payment is not made within the 45-day period, then coverage will remain terminated without possibility of reinstatement. There is no grace period for the initial payment.

The due date for subsequent payments is typically the first day of the month for any particular Period of Coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage. If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will notify You and allow You 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and Your coverage will be terminated in accordance with the Plan language above.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

LENGTH OF CONTINUATION COVERAGE

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Covered Person whose coverage terminates under the Health Care Spending Account because of a COBRA Qualifying Event will be given the opportunity to continue coverage under the Health Care Spending Account on an after-tax basis for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

Continuation coverage under COBRA may terminate before the end of the year for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same);

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations;

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare;

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan;

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
GENE B GLICK COMPANY INC
8801 RIVER CROSSING BLVD STE 200
INDIANAPOLIS IN 46240

The COBRA Administrator

FAMILY MEDICAL LEAVE ACT (FMLA)

Health Benefits. Despite any provision to the contrary in this Plan, if You are absent from work due to qualifying leave under the FMLA, then to the extent required by the FMLA, the employer will continue to maintain Your health benefits and Health FSA on the same terms and conditions as if You were still an active Employee. That is, if You elect to continue Your coverage while on leave, the employer will continue to pay its share of the contribution.

You may elect to continue Your coverage under the Health Care Spending Account during the FMLA leave. If You elect to continue Your coverage while on leave, then You may pay Your share of the contribution in one of the following ways:

- *Pay-as-You-go* with after-tax dollars, by sending monthly payments to Your employer or on a pre-tax basis to the extent the contributions are made from taxable Compensation (i.e., from unused sick days or vacation days) that You accrue during the leave;
- *Pre-pay* with pre-tax dollars, by pre-paying all or a portion of the contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation or on a pre-tax basis to the extent the contributions are made from taxable Compensation (i.e., from unused sick days or vacation days) that You accrue during the leave. To pre-pay the contribution, You must make a special election to that effect prior to the date that such Compensation would normally be made available to You (pre-tax dollars may not be used to fund coverage during the next Plan Year). In addition, contributions may also be made on an after-tax basis under this option; or
- *Catch-up* the contributions due the Plan Administrator under an arrangement agreed upon between You and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold “catch-up” amounts upon Your return).

If Your coverage ceases while on FMLA leave, 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. You may either resume coverage at Your original level and make up the unpaid contributions or resume coverage at a reduced level under the proration rule and resume contributions at Your original contribution level.

NON-FMLA LEAVES OF ABSENCES

If You are absent from work due to an unpaid leave of absence that does not affect eligibility, then You will continue to participate in the Plan and any contribution due will be paid for with one of the following options: pre-payment before going on leave, pay-as-You-go with after-tax contributions while on leave, or with catch-up contributions after leave ends, as may be determined by the Plan Administrator.

If You go on an unpaid leave that affects eligibility, the election change rules described in this SPD will apply. To the extent COBRA applies, You and Your Dependents may continue coverage under COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or on furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to waiting periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who chose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER PRIVACY AND SECURITY REGULATIONS

This Plan will Use Your Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by HIPAA. Specifically, this Plan will Use and Disclose Your PHI for purposes related to health care Treatment, Payment for health care Health Care Operations as required by law and as permitted by an authorization. This section explains the terms under which the Plan may share Your PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI. See the Glossary of Terms section of this SPD for the definitions of terms used in this provision.

This Plan shall Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations. Any Disclosure of PHI to the Plan Sponsor will only be made upon receipt of a certification from the Plan Sponsor that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor shall use and/or Disclose Your PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan and is subject to all of the following:

- The Plan Sponsor will only use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI (including Electronic PHI) to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI and to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the HIPAA and this SPD and will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If such return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Vice President of Human Resources, Benefits Compensation Specialist, Human Resources Administrator, Chief Financial Officer, Vice President of Accounting & Financial Operations, Director Payroll & Benefits Accounting, Payroll & Benefits Accountant, Payroll Specialist and President & CEO

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive Your PHI. If any of these Employees or workforce members use or Disclose Your PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to You.

STATEMENT OF ERISA RIGHTS

ERISA applies to the Health Care Spending Account plan (the Health FSA) but not the Dependent Care Spending Account plan. As a Health FSA Participant, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that You and Your Dependents 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 Health FSA including collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 Series) filed 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 that govern the operations of the Health FSA, including collective bargaining contracts, if applicable, copies of the latest annual report (Form 5500) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE HEALTH CARE SPENDING ACCOUNT BENEFITS

You can continue Health Care Spending Account benefits for Yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for such benefits. Review this SPD and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for You and Your Dependents, ERISA imposes duties upon the people who are responsible for the operation of the Health FSA. The people who operate the Health FSA, known as "fiduciaries", have a duty to do so prudently and in the interest of You and all Participants. No one, including Your employer or any other person, may terminate Your employment or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a benefit under the Health FSA is denied in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps that You may take to enforce the above rights. For instance, if You request a copy of the Plan document or the latest annual report from the Health Care Spending Account plan and You 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 Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan' Administrator's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in state and Federal court.

If it should happen that the Health FSA's fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the US 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 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 this Health FSA, contact your Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is provided to allow You to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses Incurred on behalf of a Dependent. The Dependent Care Expenses reimbursed are intended to be eligible for exclusion from gross income under Code §129(a).

ACCOUNT MINIMUMS

The minimum annual contribution is $5 per pay period.

ACCOUNT MAXIMUM

You can contribute up to $5,000, subject to the limitations set forth under Maximum Reimbursement Available.

You may not be reimbursed in excess of the contributions You have made at any point in time. Once You Incur Covered Expenses, You may file a claim and be reimbursed for up to the maximum amount of Your account balance.

MAXIMUM REIMBURSEMENT AVAILABLE (Calculated on a per taxable year basis)

You can contribute up to the *least* of the following amounts:

- The year-to-date amount that has been withheld from Your Compensation for the Dependent Care Spending Account for the Period of Coverage, less any prior reimbursements for Dependent Care Expenses during the Period of Coverage;
- Your Earned Income for the applicable month;
- Your Spouse's Earned Income for the applicable month;
- The following annual amount:
  - $5,000, if one of the following applies:
    - You are married and file a joint return;
    - You are married, but furnish more than one-half of the cost of maintaining the Dependent for whom You are eligible to receive reimbursements under the Dependent Care Spending Account, Your Spouse maintains a separate residence for the last six months of the calendar year, and You file a separate tax return; or
    - You are single or the head of the household for federal tax purposes.
  - $2,500, if You are married but You and Your Spouse file separate tax returns.
  - Your taxable Compensation (after Your Salary Reduction under applicable benefits Plan).
  - Your Spouse's actual or deemed Earned Income.

If You are married, but Your Spouse has no Earned Income, then the Employee is deemed to have an Earned Income of $250 a month ($500 a month if You have 2 or more Dependents), in each month during which Your Spouse was:

- A Full-Time Student at an educational organization during at least part of five calendar months during the calendar year; or

- Incapable of self-care due to a mental or physical condition.

If Your Spouse has a Dependent Care Spending Account through his/her employer, Your combined contribution cannot be more than $5,000. If You and Your Spouse both work for the same employer You may both contribute to the account, but may not contribute more than $5,000 combined.

TAX CONSIDERATIONS

The monies that You receive as Dependent Care Expenses under this Flexible Spending Account during the year generally are not subject to Social Security (FICA) taxes or federal or, where applicable, state and local income taxes. However, they are reported on Your W-2 form. This is required by the IRS to ensure that taxpayers do not claim the same expenses in two places. If You are using both the tax credit and the Dependent Care Spending Account, You must reduce the amount of Dependent Care Expenses that qualify for the tax credit by the amount You received from the pre-tax Dependent Care Spending Account.

You should determine whether it is more beneficial for You to use the Dependent Care Spending Account or the federal income tax credit for these expenses. You may wish to consult Your personal tax advisor. The actual determination of the preferable method for treating benefit payments depends upon a number of factors such as Your tax filing status (e.g. married, single, head of household), number of Dependents. You will have to determine Your individual tax position in order to make a decision between taxable and tax-free benefits. Generally, if You are in a lower income tax bracket, You may benefit by including the Dependent Care Spending Account benefits in income and by claiming the credits for Dependent Care and Earned Income. On the other hand, it will generally be better to treat Dependent Care Spending Account benefits as tax-free if You are in a higher tax bracket.

You may not claim any other tax benefit for the pre-tax amounts You receive under this Dependent Care Spending Account, although the balance of Your Dependent Care Expenses may be eligible for the dependent care credit.

IRREVOCABILITY RULE

Your election to participate in the account(s) is irrevocable for the duration of the Plan Year except as permitted when You experience a Change in Status. In the event of a Change in Status, the following rule would apply:

> You are not allowed to reduce Your election for Dependent Care Spending Account benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed.

In addition, any change in an election affecting the Dependent Care Spending Account pursuant to this section will also change the maximum reimbursement benefit for the Period of Coverage remaining in the Plan Year. The maximum reimbursement benefit following an election change is calculated as follows:

> Balance (if any) remaining in Your reimbursement account as of the end of the portion of the Plan Year immediately preceding the change in election
>
> \+ Plus total contributions You scheduled to make for the remainder of the Plan Year as affected by the election change
>
> ---
>
> Maximum reimbursement benefit for Period of Coverage remaining in the Plan Year

DEPENDENT CARE EXPENSES IN GENERAL

These expenses must meet all of the following conditions for them to be Eligible Dependent Care Expenses that qualify under Code §21:

- The expenses are Incurred for services rendered after the date of Your election to receive reimbursements for Dependent Care Expenses, and during the calendar year to which it applies.
- Each individual for whom You Incur the expenses is: a Dependent under the age of 13 whom You are entitled to a personal tax exemption as a Dependent, or a Spouse or other tax Dependent who is physically or mentally incapable of caring for himself or herself.
- The expenses are Incurred for the care of a Dependent, or for related household services, and are Incurred to enable You to be gainfully employed.
- If the expenses are Incurred for services outside Your household and for the care of a Spouse or other Dependent age 13 or older who is Incapable of Self-Care, such individual regularly spends at least eight hours per day in Your home.
- If the expenses are Incurred for services provided by a Dependent Care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of Yours who is under age 19 at the end of the year in which the expenses are Incurred or an individual for whom You or Your Spouse is entitled to a personal tax exemption as a Dependent.

Here are some examples of Dependent Care Expenses:

- Nursery schools (The entire cost can be treated as Dependent Care Expenses only if the amount paid for schooling is incidental to, and cannot be separated from, the cost of care.)
- Day care centers.
- Day care in Your home.
- Licensed day care center for children or adults.
- A before- or after-school program.

EXCLUSIONS

The following are examples of expenses that do not qualify for reimbursement from Your Dependent Care Spending Account:

- Payments to Your child who is under age 19 and who is caring for a younger child.
- Tuition expenses for schooling in kindergarten or higher.
- Food or clothing expenses.
- Overnight camp expenses.
- Summer school.
- Tutoring programs.
- Expenses in excess of Your taxable income or that of Your Spouse, whichever is less.
- Expenses Incurred when You are not working.
- Expenses Incurred prior to the coverage date or after the Plan Year ends.
- Expenses claimed as a deduction or credit for federal or state tax purposes.
- Other expenses that do not fall within IRS guidelines.
- Expenses Incurred if Your Spouse is not engaged in gainful employment during the hours Dependent Care is needed and the Spouse is not physically or mentally disabled or otherwise incapable of caring for Dependent(s).
- Any Expenses that does not qualify under Code §21.

FUNDING

When You complete the Salary Reduction Agreement, You specify the amount of Dependent Care Spending Account benefits for which You wish to pay with Your Salary Reduction. Thereafter, Your Dependent Care Spending Account will be credited with the portion of Your gross income that You have elected to forgo through Salary Reduction. These portions will be credited as of each pay period. The amount that is available for reimbursements at any particular time will be whatever has been credited to Your Dependent Care Spending Account as of the date of processing the request for reimbursement, less any reimbursements already paid.

For example, suppose You have elected to be reimbursed for $2,600 per year for Dependent Care Expenses. Your Dependent Care Spending Account would be credited (and funded) with a total of $2,600 during the Plan Year. Thus, if You are paid bi-weekly, You would have a total of $100 credited to Your Dependent Care Spending Account each payday to pay reimbursements under this Plan.

You may not be reimbursed for any expenses arising before the Dependent Care Spending Account becomes effective, before Your Salary Reduction agreement becomes effective, for any expenses Incurred after the close of the Plan Year, or after a separation from service.

SUBMITTING DEPENDENT CARE CLAIMS

When You Incur an expense that is eligible for payment, submit a claim to UMR a claim form supplied to You. You must submit a written statement from an independent third party (the qualified caregiver) indicating their tax identification number or social security number, the date the services were provided, and the amount of the expense. This documentation fulfills the claims substantiation requirements by the IRS.

If there are enough credits (Your contributions) to the Dependent Care Spending Account, You will be reimbursed for Your Covered Expenses within the month that follows the month You submitted Your claim.

If Your claim is for an amount that is more than Your current account balance, the excess part of the claim will be carried over into following months, to be paid as Your balance becomes adequate. Please note that it is not necessary that You have actually paid an amount due for a Covered Expense — only that You have Incurred the expense. You must also attest to the fact that this expense is not being paid for or reimbursed from any other source. Claim forms will contain this detail.

TIMELY FILING

You will have 92 days after the end of the Plan Year or 90 days following termination to submit a claim for reimbursement for a Covered Expense Incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

YOUR CERTIFICATION

The benefit of using a flexible spending account is that You receive pre-tax dollars for qualified expenses. In this way, a flexible spending account alters Your income tax liability for which You are solely responsible. UMR and this Plan are not liable for any penalties or damages as a result of an inappropriate claim being filed.

There are rules that You must follow under the terms of this Plan, which are set forth in the following certification. This certification can be found on the claim form so that each time You submit a claim, You can refer to the rules that You must follow when submitting claims to Your flexible spending account.

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were Incurred for services or supplies received by me or my eligible Dependents under the Plan.
- They were for services and/or supplies furnished on or after the Effective Date of my Health Care and/or Dependent Care Spending Accounts.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all Plans under which my eligible Dependents and I are covered.

I further certify that I have not deducted, nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care and/or Dependent Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the Health Care and/or Dependent Care Spending Account plan. I accept responsibility for the proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting and liability.

FRAUD

Fraud is a crime that can be prosecuted. Anyone who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime if You file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions, as well as submission of false information, will result in denial of Your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

As a Participant, You must:

- File accurate claims. If someone else - such as Your Spouse or another family member - files claims on Your behalf, You should review the form before You sign it;

- Review the Explanation of Benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses Incurred and the services rendered;

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.

To maintain the integrity of Your Plan, You are encouraged to notify the Plan whenever a provider:

- Bills You for services or treatment that You have never received;

- Asks You to sign a blank claim form; or

- Asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

RECORDKEEPING AND ADMINISTRATION

PLAN ADMINISTRATOR

The administration of this Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

POWERS OF THE PLAN ADMINISTRATOR

The Plan Administrator has such duties and powers as it considers necessary or appropriate to discharge its duties. It has the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding upon all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan to prescribe procedures to be followed and the forms to be used to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;
- To request and receive such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- To furnish each Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- To receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines to be necessary and proper;
- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary and advisable, including legal counsel and benefit consultants;
- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable Disclosure and reporting requirements.

RELIANCE

The Plan Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

COMPENSATION OF PLAN ADMINISTRATOR

Unless otherwise determined by the employer and permitted by law, any Plan Administrator who is also an Employee of the employer shall serve without Compensation for services rendered in such capacity, but all reasonable expenses Incurred in the performance of their duties shall be paid by the employer.

INABILITY TO LOCATE PAYEE

The Plan Administrator shall make reasonable efforts to locate Participants. In the event that the Plan Administrator is unable to make benefit payment to a Participant, the Plan Administrator will hold benefit payment until the location of the Participant is known or until one (1) year after the end of the Plan Year in which the benefit was payable.

EFFECT OF MISTAKE

In the event of a mistake as to eligibility, allocation of elected contribution amounts, or the payment of benefits under the Plan, the Plan Administrator reserves the right to correct the mistake, to the extent possible, using any available legal means.

GENERAL PROVISIONS

EXPENSES

All reasonable expenses Incurred in administering the Plan are currently paid by forfeitures to the extent provided by the Plan, and then by the employer.

NO CONTRACT OF EMPLOYMENT

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any eligible Employee and the employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the employer.

The Plan Sponsor fully intends to maintain this Plan indefinitely, however the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan.

The Plan Administrator will provide written notice to You within 60 days following the adopted formal action that makes material changes to the Plan.

AUTHORIZED AGENT TO SIGN AND AUTHORIZE AMENDMENT

Any amendment that is signed and acknowledged by the employer will be deemed to be a valid amendment.

YOUR RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, Your rights are limited to Covered Expenses Incurred before You receive notice of termination.

The Plan will assume that You received the written amendment or termination letter from the Plan three days after the Plan mails the letter to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

GOVERNING LAW

This Plan shall be construed, administered and enforced according to the laws of the State of Indiana, to the extent not superseded by the Code, or preempted by ERISA or any other federal law.

CODE AND ERISA COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. (ERISA applies to the Health Care Spending Account section of this Plan only.) This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

In the event that the Plan fails a nondiscrimination test, the Plan Administrator reserves the right to decrease contribution levels of Highly Compensated or Key Employees.

NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the employer makes any commitment or guarantee that any amounts paid to or for Your benefits under this Plan will be excludable from gross income for federal, state or local income tax purposes. It shall be Your obligation to determine whether each payment under this Plan is excludable from Your gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if there is any reason to believe that such payment is not excludable.

INDEMNIFICATION OF EMPLOYER

If You receive one or more payments or reimbursements that are not for Medical Care Expenses or for Dependent Care Expenses, You must indemnify and reimburse the employer for such amounts, including any liability it may Incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements. Any such amounts may be withheld from an Employee's paycheck to the extent permitted by law. If at the end of the Plan Year You have not reimbursed the Plan for the improper payment, the Plan Sponsor will treat the improper payment as it would any other business indebtedness.

NON-ASSIGNABILITY OF RIGHTS

Your right to receive any reimbursement under this Plan shall not be alienable by assignment or any other method and shall not be subject to claims by Your creditors through any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

FORFEITURE OF STALE CHECKS

Any checks that you receive for reimbursement of expenses must be cashed on a timely basis. In particular, the Plan may stop payment on any check that has not been deposited or cashed within one (1) year after the close of the Plan Year in which the check was issued. Any such amounts will be forfeited and used to defray the reasonable expenses associated with administering this Plan.

PLAN HEADINGS

The headings of the various articles and sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of the Plan, the provision of this Plan shall be controlling.

SEVERABILITY

Should any part of this SPD be invalidated by a court of competent jurisdiction, the remainder of the SPD shall be given effect to the maximum extent possible.

GLOSSARY OF TERMS

Accredited Institution of Higher Education means, for the purposes of this Plan, a two-year or four-year degree-granting college or university or licensed trade school and which is accredited in the current publication of Accredited Institutions of Higher Education.

Administrative Simplification means the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that You are no longer eligible to participate in a Plan.

Business Associate (BA) with respect to a Covered Entity (CE), means a person to whom the CE Discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other covered entities. This excludes persons who are within the CE's workforce.

Cafeteria Plan is a written plan in which all participants are Employees who may choose between two or more benefits consisting of cash and “qualified benefits” as permitted by Code §125.

Change in Cost means a significant cost increase or a significant cost decrease as determined by the Plan Administrator and applies uniformly to all Covered Persons. A Dependent Care provider who is a relative of the Employee cannot impose the cost change. A relative is an individual who is related as described in Code §152(d), incorporating the rules of Code §152(f).

Change in Coverage means that a Covered Person may make a prospective election change that is on account of and corresponds with a Plan benefit change by the employer.

Change in Status means any of the events described in the Change in Status Provision within this SPD.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA is a federal law that gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Code means the Internal Revenue Code of 1986, as amended.

Common-Law Employee in general, the IRS considers an Employee a Common-Law Employee if the company requesting the service has the authority to control what will be done and how it will be done. The Plan Administrator shall adhere to the IRS's Three-Part Analysis relating to behavioral control, financial control, and the relationship of the parties.

Compensation means the wages or salary paid to an Employee by the employer, determined prior to any Salary Reduction election under this Plan, prior to any Salary Reduction election under any other Code §125 Cafeteria Plan, and prior to any salary deferral election under any Code §401(k), 403(b) or 408(k) arrangement.

Cosmetics as defined by the Food, Drug, and Cosmetic Act is an article intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body for cleansing, beautifying, promoting attractiveness, or altering the appearance.

Cosmetic Surgery means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Entity (CE) means one of the following: a Health Plan, a healthcare clearinghouse, or a healthcare provider who transmits any health information in connection with a transaction covered by this law.

Covered Expense means any expense or portion thereof, which is Incurred as a result of receiving an eligible benefit under the Health Care Spending Account or the Dependent Care Spending Account, which ever is applicable.

Covered Person means You and Your Dependents who are enrolled in component benefit plans offered by Your employer under this Plan.

Dependent means any individual who:

- For purposes of the Health Care Spending Account, is a tax Dependent of the Participant as defined in Code §105(b) or Code §125(e), as applicable, (this includes relatives and non-relatives who receive over 50% of their support from the Participant), and

- For purposes of the Dependent Care Spending Account, is a person defined in Code §21(b)(1) with respect to the Participant and in the case of divorced parents, the child shall, as provided in Code §21(e)(5), be treated as a Dependent of the custodial parent and shall not be treated as a Dependent of the non-custodial parent. (See the Health Care and Dependent Care Spending Account provisions for further details regarding Dependent eligibility).

Dependent Care Expenses means expenses that are considered to be Eligible Employment-Related Expenses under Code §21(b)(2) (relating to expenses for household and Dependent Care Services necessary for gainful employment of the Employee and Spouse, if any), if paid for by the Employee to provide Qualifying Dependent Care Services.

Dependent Care Services means services relating to the care of a Qualifying Individual that enable the Covered Person and Spouse to remain gainfully employed, which are performed inside or outside the Covered Person's home for:

- The care of a Dependent of the Covered Person who is under age 13.

- The care of any other Qualifying Individual that resides at least eight hours per day in the Covered Person's household.

If the expenses are Incurred for services provided by a Dependent Care center (i.e., a facility that provides care for more than six individuals not residing at the facility), then the center must comply with all applicable state and local laws and regulations.

Dependent Care Spending Account means the Dependent Care Spending Account as described in this Plan.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is defined as the release or divulgence of information by an entity or one of its Employees to persons or organizations outside of that entity.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other Employee Compensation (such as disability or wage continuation benefits), but does not include:

- Any amounts received pursuant to any Dependent Care assistance program under Code §129.
- Any amounts received as a pension or annuity.
- Or any amounts received pursuant to workers compensation.

Effective Date means the first day of coverage under this Plan as defined in this SPD.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Eligible Employment-Related Expenses means those Qualifying Dependent Care Services Incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care Spending Account of this Plan and during the Plan Year, other than amounts paid to:

- An individual with respect to whom a Dependent deduction is allowable under Code §151(c) to the Participant or his or her Spouse.
- The Participant's Spouse.
- A child of the Participant (within the meaning of Code 152(f)) who is under 19 years of age at the end of the year in which the expenses were Incurred.

For this purpose, a Dependent Care Expense is Incurred only after the services giving rise to the expense have actually been rendered.

Employee - see the Eligibility and Enrollment section of this SPD.

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the employer for Compensation.

Enrollment Date means:

- For any Employee who applies for coverage when first eligible, the first day of the waiting period.
- For any Employee who enrolls under the Special Enrollment Provision, the Enrollment Date is the first day of coverage.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Full-Time Student or Student means a Student attending high school or an Accredited Institution of Higher Education. To be considered Full-Time Students, Dependents must attend at least 12 credits per semester or 6 credits per semester for graduate studies, or equivalent if the school operates on an alternative term basis. Alternatively, the Student must meet the accredited college or university's definition of Full-Time Student. Students attending a combination of accredited institutions and whose total combined attendance meets the requirements listed in this paragraph also will qualify as Full-Time Students. With respect to a licensed trade school, attendance requires enrollment in a 6 month or longer training program for at least 20 hours per week that awards a formal certification upon graduation and the school must be accredited by a national governing body.

Health Benefit Plan means the plan(s) that the employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (including HMOs). The employer may substitute, add, subtract, or revise at any time the menu of such Plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Covered Persons and will automatically be incorporated by reference under this Plan.

Health Care Operations means general administrative and business functions necessary for the Covered Entity to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and Health Plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about treatment alternatives, and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Health Care Spending Account (Health FSA) means the Health Care Spending Account described in this Plan.

Health Plan means any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulation, 65 Fed. Reg No. 250 (82463).

Highly Compensated Employee means Employees in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans. The specific definition differs depending on the type of plan and the nondiscrimination requirement at issue.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of Protected Health Information among other things.

Illness means sickness or disease. Pregnancy and complications of pregnancy are considered an Illness under this Plan.

Incapable of Self-Care means incapable of caring for his or her hygienic or nutritional needs, or requires full time attention of another person for his or her own safety or the safety of others.

Incurred means the date the service or treatment is provided, the supply is received or the facility is used, without regard to when the service, treatment, supply, or facility is billed, charged or paid.

Independent Contractor means an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with § 530 of the Internal Revenue Code.

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present or future payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Persons.

Key Employee is defined as an Employee who is an officer or shareholder of the employer (as further defined in Code 416) and in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans.

Medical Care Expense means an expense Incurred by a Covered Person, for medical care as defined in Code §213 (including, for example, amounts for certain hospital bills, doctor and dental bills), other than expenses that are excluded hereunder, but only to the extent that the Covered Person Incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Benefit Plan, other insurance, or any other accident or Health Plan.

Medically Necessary or Medical Necessity means treatment, services, supplies, Medicines, or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and which meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a medical condition; and
- Is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- Is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- Is cost effective for this condition, compared to alternative interventions, including no intervention. Cost effective does not necessarily mean the lowest price; and
- Not primarily for the convenience or preference of the Covered Person, his or her family or any provider; and
- It is not Experimental, Investigational, Cosmetic or Custodial in nature; and
- Is currently or at the time the charges were Incurred recognized as acceptable medical practice by the Plan.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, Medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, equipment or facility Medically Necessary.

Medicine or Medication means a substance or preparation that alleviates or treats a sickness, disease, or injury.

Merchant means one whose occupation is the wholesale purchase and retail sale of goods for profit.

Ordinary Care means the degree of care, skill and diligence that a reasonable and prudent administrator would exercise in making a fair determination on a claim for benefits of like kind to the claim involved.

Over-the-Counter Drugs/Items means those Medicines or other items that are available to consumers without a Physician's prescription and are used to alleviate or treat a sickness, disease, or injury.

Participant means a person who is an eligible Employee and who is participating in this Plan in accordance with applicable provisions of this Plan. Participants include:

- Those who elect to salary reduce to pay for the benefits offered under this Plan.
- Those who elect to receive their full salary in cash and pay for their share of their contributions under the Health Benefit Plan (if any) with after-tax dollars outside of this Plan and who have not elected any benefits under this Plan.

Payment means the activities of the Health Plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Period of Coverage means the Plan Year, with the following exceptions: (1) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences and (2) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: doctor of medicine (MD); doctor of medical dentistry including an oral surgeon (DMD); doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of optometry (OPT). Subject to the limitations below, the term Physician shall also include the following practitioner types: physician assistant (PA); nurse practitioner (NP); certified nurse midwife (CNM); or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan means the GENE B GLICK COMPANY INC Flexible Spending Plan. It consists of a Cafeteria Plan, Health Care Spending Account and a Dependent Care Spending Account.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Plan Administrator means GENE B GLICK COMPANY INC.

Plan Sponsor means any employer who sponsors a group Health Plan.

Plan Year means the consecutive twelve (12) month period of time, designated in the Plan Information section of this SPD, during which the Plan is maintained.

Privacy Official is defined as the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information means Individually Identifiable Health Information that is transmitted by electronic media, or maintained in any medium that is considered electronic media, or transmitted or maintained in any other form or medium.

QMCSO means Qualified Medical Child Support Order as defined in ERISA 609(a).

Qualifying Individual for purposes of the Dependent Care Spending Account means:

- Dependent of the Covered Person who is under the age of 13.
- Dependent of a Covered Person who is mentally or physically Incapable of Self-Care.
- Spouse of a Covered Person who is mentally or physically Incapable of Self-Care.

Qualified Reservist Distribution - see the Health Care Spending Account section of this SPD.

Salary Reduction means the amount by which the Covered Person's Compensation is reduced and applied by the employer under this Plan to pay for one or more of the benefits provided under this Plan.

Spouse means an individual who is legally married to a Participant (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Spending Account, the term "Spouse" shall not include:

- An individual legally separated from the Participant under a divorce or separate maintenance decree.
- An individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal resident from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Summary Health Information means information, that may be Individually Identifiable Health Information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a Health Plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for Payment of benefits under this Plan.

Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care.

Treatment means the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the Health Plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

You or Your means the Employee under the Plan.