County of Currituck Flexible Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective July 1, 2020

Summary Plan Description
With Premium Payment, Health FSA, and DCAP Components

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Summary Plan Description

Article I
INTRODUCTION

County of Currituck, (the "Employer") sponsors the County of Currituck Flexible Benefit Plan (with Premium Payment, Health FSA, and DCAP Components) (the "Cafeteria Plan") that allows Eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. Alternatively, Eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary Plan Description (SPD) describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan and is not meant to interpret or change the provisions of your Plan. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the Cafeteria Plan document and this Summary, the Cafeteria Plan Document shall govern.

Article II
PARTICIPATION IN YOUR PLAN

How can I participate in the Cafeteria Plan?
Once an Employee has met the Plan's eligibility requirements, and provided that the election procedures outlined under **'How do I become a Participant and when is my Entry Date?'** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?
Employees who are eligible to participate in the Employer's group medical insurance and are employed by a participating Employer may participate in the Plan once they meet the eligibility requirements and provided that the election procedures outlined under '**How do I become a Participant?**' section are followed.

Eligibility for the Premium Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Medical Insurance Plan.

Are there any Employees who are not eligible to participate in the Plan?
The following Employees are excluded from participating in the Plan: Employees covered by a collective bargaining agreement as to which welfare benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in the Plan, Non-resident aliens with no US source of income, "Leased employees" within the meaning of Section 414(n), and self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

How do I become a Participant and when is my Entry Date?
After you satisfy the eligibility requirements described under **'What are the Eligibility Requirements to participate in the Cafeteria Plan?',** you will automatically be enrolled in the Premium Payment Benefits, with the employee's salary reduced pretax to pay for a portion of the cost of the coverage, unless the employee affirmatively elects otherwise before a date specified in the open enrollment materials.

An Eligible Employee who fails to complete, sign, and return an Election Form/Salary Reduction Agreement, (or waiver of pre-tax premiums) as required, for subsequent Plan Years, then the Employee: shall continue with same elections as prior year for insured/premium benefits.

If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Premium Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as explained under **'Can I change my elections under the Cafeteria Plan during the Plan Year?'),** a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

Employees who actually participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until: (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for Premium Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See **'What is Continuation Coverage and how does it work?',** and **'What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?'** for information about how termination of participation affects your Benefits.

What is the "Open Enrollment Period" and the "Plan Year"?
The Open Enrollment Period is the period during which you have an opportunity to participate under the Cafeteria Plan or decline coverage and have no salary reduction.

You will be notified of the timing and duration of the Open Enrollment Period prior to the beginning of the new Plan Year. The Plan Administrator will inform all Participants of the applicable dates for each annual enrollment period.

The Plan Year is the 12 months beginning on each July 1st and ending on June 30th.

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?
If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for the Premium insurance benefits, Health FSA, and DCAP benefits.

The Premium Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

See '**What is Continuation Coverage and how does it work?**' and the booklets for the Medical Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see '**What must I do to be reimbursed for Medical Care Expenses from the Health FSA?**'.

For reimbursement of expenses from the DCAP Account after termination of employment, see '**What must I do to be reimbursed for my Dependent Care Expenses?**'.

For purposes of pre-taxing COBRA coverage for Premium Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See '**What is Continuation Coverage and how does it work?**'.

If you are rehired within 30 days or less during the same Plan Year and are eligible for the Cafeteria Plan, then your prior elections will be reinstated.

If you are rehired more than 30 days after you terminated employment, and are eligible for the Cafeteria Plan, you may not rejoin the Plan until the first day of the following Plan Year, regardless of whether or not a Change in Status occurs. Any unused reimbursement benefit account balance prior to the initial separation of service date will be forfeited.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described under **'How can I participate in the Cafeteria Plan?'** before again becoming eligible to participate in the Plan.

What is "Continuation Coverage" and how does it work?
To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the medical insurance plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), may be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the medical insurance plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for medical insurance benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where

COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for medical insurance benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, who has a separation from service or whose coverage terminates under the Health FSA Benefit because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) may be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Benefit the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals may be eligible for COBRA continuation coverage regardless of the Health FSA Account balance at the end of the applicable Period of Coverage (taking into account all claims submitted before the date of the qualifying event).

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage; such COBRA coverage for the Health FSA Benefit will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Participants with underspent Health FSA Accounts can continue Health FSA benefits only through the end of the year in which the COBRA qualifying event occurs. Qualified beneficiaries who continue coverage through June 30th may carry over up to $550 of unused Health FSA amounts remaining at the end of a Plan Year in accordance with the Plan's provisions regarding Health FSA carryovers.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into the new Plan Year) where COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction of hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits may be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into the new Plan Year).

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

How does a leave of absence (such as under FMLA) affect my benefits?
The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to permit eligible employees to take up to 12 weeks of unpaid, job-protected leave each year because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of the employee's own serious health condition. The FMLA also permits an eligible employee to take up to 12 workweeks of leave during any 12-month period for a "qualifying exigency" arising because the employee's spouse, son, daughter, or parent is on active duty (or has been notified of a call or order to active duty) in the Armed Forces in support of a "contingency operation." In addition, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member is entitled to take up to 26 workweeks of leave during a 12-month period to care for the service member. These FMLA provisions have been further amended regarding qualifying exigency leave and covered service member leave for employees who are relatives of veterans and members of the

Armed Forces.

FMLA Leaves of Absence
If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Premium insurance benefits, and Health FSA benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Premium Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

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

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

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

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

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

appropriate.

Non-FMLA Leaves of Absence
If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid:

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

If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see **'When Can I Change Elections Under the Cafeteria Plan During the Plan Year?').**

Article III
PAYING FOR YOUR BENEFITS UNDER YOUR PLAN

How do employees pay for benefits on a pre-tax basis?
An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer (ask Human Resources for a copy if you have not received one). Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Will I pay any administrative costs under the Cafeteria Plan?
The cost of the plan includes administrative expenses and is paid partially by the Employer and partially by the Employees, as explained in the open enrollment materials. The cost of the plan includes administrative expenses and is paid in part by the use of forfeitures, if any. (See **What are the time limits that affect forfeiture of my Health FSA Benefits?** and **What are the time limits that affect forfeiture of my DCAP Benefits?**) The rest of the cost of administering the Cafeteria Plan is paid entirely by the Employer.

Can I change my elections under the Cafeteria Plan during the Plan Year?
You generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

When can I change elections under the cafeteria plan during the Plan Year?
Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various 'Change in Election Events' headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined under '**How do leaves of absence (such as under FMLA) affect my benefits?**'); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence.

If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence
(Applies to Medical Insurance Benefits, Health FSA, and DCAP Benefits)
You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described under **'How do leaves of absence (such as under FMLA) affect my benefits?'**

2. Change in Status.
(Applies to Medical Insurance Benefits, Health FSA, and DCAP Benefits) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

* a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
* a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
* any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
* an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, or a similar circumstance); or
* a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements.
(Applies to Medical Insurance Benefits, Health FSA, and DCAP Benefits)
If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined under '**What are "Dependent Care Expenses" that may be reimbursed?**') for the dependent care tax exclusion).

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

* *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits (the Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See '**What is "Continuation Coverage" and how does it work?**'.

* *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

* *DCAP Benefits.* With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

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

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have. Contact the Plan Administrator if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to Medical Insurance Benefits and Health FSA Benefits)* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Medical Insurance Benefits and Health FSA Benefits)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable).

7. Change in Cost. *(Applies to Medical Insurance Benefits and DCAP Benefits)* If the cost charged to you for your Medical Insurance Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; and (b) coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.)

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases in the cost of DCAP benefits. The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage. *(Applies to Medical Insurance Benefits and DCAP Benefits)* You may also change your election if one of the following events occurs:

* *Significant Curtailment of Coverage.* If your Medical Insurance Benefits and DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits and DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

* *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

* *Loss of Other Group Health Coverage.* You may prospectively change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP); a medical care program of certain Indian Tribal programs or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

An election change on account of a HIPAA special enrollment attributable to an employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 60 days).

* *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

* *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

Article IV
WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What benefits may be elected under the Cafeteria Plan?
The Cafeteria Plan includes the following benefit plans:

Premium Payment Benefits (currently including Premium Insurance Benefits) - permits an Employee to pay for his or her share of contributions for the Medical Insurance Plan with pre-tax dollars. "Medical Insurance Plan" means the major medical plan that your Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy.

Here, these benefits include Basic Health, Dental, and Vision options. Benefits provided under the Medical Insurance Plan are called "Premium Insurance Benefits." Benefits provided generally under the Premium Payment Benefits (including any benefits that may be added at a later date) are called "Premium Payment Benefits";

Health Flexible Spending Arrangement (Health FSA) also called a medical expense reimbursement plan - permits an Employee to pay for his or her qualifying Medical Care Expenses (defined under '**What are Medical Care Expenses that may be reimbursed from the Health FSA?**') that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called "Health FSA Benefits." As described under '**What are Medical Care Expenses that may be reimbursed from the Health FSA?**', the Health FSA election may be for:

* General-Purpose Health FSA Coverage.

Dependent Care Assistance Program (DCAP) also called a dependent care flexible spending account- permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined under '**What are Dependent Care Expenses that may be reimbursed?**') with pre-tax dollars. Benefits provided under the DCAP are called "DCAP Benefits."

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Article V
HOW BENEFITS ARE TAXED

What tax savings are possible under the Cafeteria Plan?
You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Insurance Benefits under the Cafeteria Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Insurance Benefits for family coverage is an annual total of $4,400. Suppose also that your gross pay is $75,000, your Spouse (a student) earns no income, and you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce $4,400 to pay for the Premium Insurance contributions, then your annual take-home pay would be $59,269. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $58,272. This is because by participating in the Cafeteria Plan for Premium Insurance contributions, you will be considered for tax purposes to have received $70,600 in gross pay, so you save $997 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Caution: The amount of the contributions used in this example is not meant to reflect your actual contributions—the actual contribution amounts will be determined by you.

	Cafeteria Plan*	No Cafeteria Plan
1. Adjusted Gross Income	$75,000	$75,000
2. Salary Reductions for Premiums	($4,400)	$0
3. W-2 Gross Wages (line 1 minus line 2)	$70,600	$75,000
4. Standard Deduction	($24,400)	($24,400)
5. Taxable Income (line 3 minus line 4)	$46,200	$50,600
6. W-2 Gross Wages	$70,600	$75,000
7. Federal Income Tax	($5,156)	($5,684)
8. FICA Tax (7.65% of line 3)	($5,401)	($5,738)
9. After-Tax Premium Payments	$0	($4,400)
10. Pay After Taxes and Premium Payments (line 6 minus lines 7, 8, & 9)	$60,043	$59,178

* Based on the standard deduction and federal income tax rates for 2019, as found in Rev. Proc. 2018-57, 2018-827 I.R.B. 827.

How will participating in the Cafeteria Plan affect my Social Security and other benefits?
Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits.

Will I be taxed on the Health FSA Benefits that I receive?
Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth under '**What are the maximum Health FSA Benefits that I may elect?**'. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

Will I be taxed on the DCAP Benefits I receive?
Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth under '**What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?**'. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are, and are not likely to be reimbursable.

Article VI
PREMIUM INSURANCE BENEFIT ACCOUNT

What are "Premium Payment Benefits"?
As described under **'How do employees pay for benefits on a pre-tax basis?',** if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Premium Insurance Benefits with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See '**How Benefits Are Taxed?**'.

The only Premium Payment Benefits offered under your Plan are for Premium Insurance Benefits, this is major medical insurance, including Basic Health, Dental, and Vision options.

How are my Premium Payment Benefits paid?
As described under '**How do employees pay for benefits on a pre-tax basis?**' and '**What are "Premium Payment Benefits?**', if you select the Medical Insurance Plan described under '**What are Premium Payment Benefits?**', then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Article VII
HEALTH FSA ACCOUNT

What are "Health FSA Benefits"?
As described under '**What benefits may be elected under the Cafeteria Plan?**', a Health FSA permits Eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Medical Insurance Plan).

As described under '**How do employees pay for benefits on a pre-tax basis?**', if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See '**What tax savings are possible under the Cafeteria Plan?**' for an example dealing with pre-tax payment of Premium Insurance contributions. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

After you satisfy the eligibility requirements described above, you may participate in the Health FSA on the same day as the Employer's group medical plan by signing an individual Election Form/Salary Reduction Agreement as described under '**How do I become a Participant and when is my Entry Date?**'

What is my "Health FSA Account"?
If you elect Health FSA Benefits, then an account called a "Health FSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

A Health FSA election may be for:

* General-Purpose Health FSA Coverage.

How are my Health FSA Benefits paid for under the Cafeteria Plan?
When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to be reimbursed up to $1,000 per year for Medical Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of $1,000 during the Plan Year. If you are paid bi-weekly, then your Health FSA Account would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected. The Employer makes no contribution to your Health FSA Account.

What are the maximum Health FSA Benefits that I may elect?
You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the maximum salary reduction contributions of $2,750 under the General-Purpose Health FSA per Plan Year. The maximum limit may increase from year-to-year pursuant to Section 125(i) of the Internal Revenue Code.

You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

What are Health FSA carryovers?
You may carry over up to $550 of unused amounts remaining in your Health FSA at the end of a Plan Year to be used for Medical Care Expenses incurred during the next Plan Year, beginning with any unused amounts remaining at the end of the current Plan Year. No more than $550 of your unused Health FSA amount for a Plan Year may be carried over for use in the next Plan Year. The maximum limit may increase from year-to-year pursuant to Section 125(i) of the Internal Revenue Code.

> ***Example:*** At the end of the 2020 Plan Year, your unused health FSA amount is $800. You may carry over up to $550 to reimburse 2021 Plan Year expenses. However, the entire $800 is also available to reimburse 2020 Plan Year expenses during the 2020 run-out period. Assume that, during the run-out period for 2020, you submit and are reimbursed for 2020 expenses of $350. This leaves you with a carryover of $450 ($800 - $350), which can be used for 2021 expenses. On the other hand, if you do not submit 2020 expenses during the run-out period, you will be able to carry over the maximum permitted amount of $550. The remaining amount will be forfeited.

Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the Health FSA.

> ***Example:*** Assume that for 2017, you elect the maximum Health FSA Benefit amount permitted under the Plan. Your election will not affect your carryover, and you can also carry over the maximum permitted amount of $500 from 2016 to 2017.

If you are otherwise eligible for the Health FSA for a Plan Year, but you do not make a Health FSA election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year Medical Care Expenses (in accordance with Plan terms). However, an Employee must be a participant in the Health FSA as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made.

What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?
The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, suppose that you elected $1,000 of coverage and contributed to your Health FSA Account (as described under '**How are my Health FSA Benefits paid for under the Cafeteria Plan?**') during January and February-that means that by February 24 you would have contributed $153.84 ($38.46 times four pay periods). You haven't made any prior claims for reimbursement during the calendar year, but on February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at that point. In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any.

> *Example:* Suppose that for 2016, you elected $1,000 of coverage and contributed to your Health FSA Account during January and February—that means that by February 24 you would have contributed $153.84 ($38.46 multiplied by 4 pay periods). On February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at that point.

What are "Medical Care Expenses" that may be reimbursed from the Health FSA?
Your Health FSA election may be for:

* General-Purpose Health FSA Coverage.

The eligible "Medical Care Expenses" vary according to the type of Health FSA coverage option that is elected, as described below.

* *General-Purpose Health FSA Coverage Option.*
For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d).

The Plan's provisions regarding permissible pre-tax benefits have been amended to provide that medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Care Expenses reimbursable under the Plan's Health FSA Component, if the expenses for these items are incurred on or after April 1, 2020. In addition, expenses for menstrual care products incurred by you, your Spouse, or your Dependents on or after April 1, 2020, will qualify as Medical Care Expenses. For this purpose, menstrual care product means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

EXCLUSIONS:

* health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Medical Insurance Plan);
* long-term care services;
* 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 a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
* the salary expenses of a nurse to care for a healthy newborn at home;
* funeral and burial expenses;
* household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
* custodial care;
* the cost of sending a child with behavioral problems to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school isn't a principal reason for sending the student there;
* social activities, such as dance lessons (even if recommended by a physician for general health improvement);
* bottled water;
* cosmetics, toiletries, toothpaste, etc.;
* uniforms or special clothing, such as maternity clothing;
* automobile insurance premiums;
* marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
* any item that doesn't constitute "medical care" under Code § 213(d); and
* any item that isn't reimbursable under applicable regulations.

Ask the Plan Administrator if you need further information regarding which expenses are reimbursable under your plan.

Note: For purposes of the new income exclusions under Code sections 105(b) and 106, the term "child" includes adult children under the age of 26 and that is the employee's son, daughter, stepson, stepdaughter, legally adopted individual (or an individual placed with the employee for adoption), and eligible foster child. Under Notice 2010-38, such a child does not have to satisfy the age limits, residency, support and other tests described in Section 152 of the Code in order to be considered an employee's child for purposes of these new income exclusions. Further, a child ceases to be a dependent as of the end of the taxable year in which they turn 26.

When must the Medical Care Expenses be incurred for the Health FSA?
For Medical Care Expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Cafeteria Plan, a 12-month period beginning on July 1st and ending on June 30th.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Cafeteria Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage, as described under '**What is "Continuation Coverage" and how does it work?**').

Can I Continue Health FSA Coverage After Terminating Employment or Incurring a COBRA Event?
The only way a Participant and his or her Spouse and Dependents, as applicable, may continue the same coverage that he or she had under the Health FSA Benefit before the qualifying event, is to elect COBRA either on a self-pay basis or, if applicable, or to continue with salary reductions.

Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the applicable Period of Coverage. COBRA coverage generally ends for the Health FSA Benefit at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Please refer to your COBRA Notice for further explanation regarding your specific situation.

Contributions for COBRA continuation for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year. Generally for Employees who have incurred a COBRA qualifying event as a result of no longer being actively employed, payments must be made on an after-tax basis.

What must I do to be reimbursed for Medical Care Expenses from the Health FSA?
When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the insurance provider (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form. You will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15 day extension for matters beyond the Plan Administrator's control-see '**What happens if my claim for benefits is denied?**'). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until the 90th day after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. If you have ceased to be eligible as a Participant, you will have until 90 days after the end of the Plan Year in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible.

Medical Care Expenses incurred during a Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses, cannot exceed $550, and will count against the $550 maximum carryover amount. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

> *Example:* At the end of the 2020 Plan Year, your unused health FSA amount is $800. You may carry over up to $550 to reimburse 2021 Plan Year expenses. However, the entire $800 is also available to reimburse 2020 Plan Year expenses during the 2020 run-out period. Assume that, during the run-out period for 2020, you submit and are reimbursed for 2020 expenses of $350. This leaves you with a carryover of $450 ($800 - $350), which can be used for 2021 expenses. On the other hand, if you do not submit 2020 expenses during the run-out period, you will be able to carry over the maximum permitted amount of $550. The remaining amount will be forfeited.

To have your claims processed as soon as possible, please read '**What happens if my claim for benefits is denied?**'. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense, only for you to have incurred the expense (as defined under '**When must the Medical Care Expenses be incurred for the Health FSA?**') and that it is not being paid for or reimbursed from any other source.

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

Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?
Yes. If the Medical Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health FSA Benefits (increased by any carryovers from the previous Plan Year, if applicable), you will forfeit any amounts that are not eligible for carryover to the following Plan Year (as defined under **'What are Health FSA carryovers?'**). This is called the use-or-lose rule under applicable tax laws. The difference between what you elected (increased by any carryovers from the previous Plan Year, if applicable) and the Medical Care Expenses that were reimbursed will be forfeited at the end of the time limits (as defined under **'What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?'** to the extent not carried over (as described under **'What are Health FSA carryovers?)'**.

Unused amounts relating to a health FSA may not be cashed out or converted to any other taxable or nontaxable benefit.

USERRA
Uniformed Services Employment and Reemployment Rights Act (USERRA)
If you are going into or returning from military service, you may have special rights to health care coverage under your Health FSA under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

Qualified Reservist Distribution
Under the Health FSA Component, a Participant may receive a distribution of all or a portion of the balance in their account if the distribution qualifies as a "Qualified Reservist Distribution".

In order for a distribution to be a "qualified reservist distribution", a number of requirements must be satisfied. First, a "qualified reservist distribution" can be made only to a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve; Air National Guard of the United States; or the Reserve Corps of the Public Health Service. Second, the distributions can be made only to a reservist that, by reason of being a member of a "reserve component", has been ordered or called into active duty (i) in excess of 179 days or more or (ii) for an indefinite period. Third, the amount of the distribution must be for "all or a portion of the balance in the employee's account". Fourth, the distribution must be made within a certain timeframe. The period for making a qualified reservist distribution must be made on or before the last day of the coverage period that includes the date of the reservist's call to active duty and ends on the last day that reimbursements could otherwise be made for the plan year that includes the first day of the distribution period.

A Qualified Reservist will be allowed to cash out the unused benefits and not forfeit them under the "use it or lose it" rule that applies to health FSAs. Specifically, the HEART Act allows for a taxable, penalty-free "qualified reservist distributions" from a health FSA without subjecting other amounts in the cafeteria plan or health FSA to immediate taxation.

What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?
You will forfeit any amounts in excess of $550 in your Health FSA Account that are not applied to pay expenses submitted by the 90th day following the end of the Plan Year for which the election was effective.

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Will I be taxed on the Health FSA Benefits that I receive?
Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth under '**What are the maximum and minimum Health FSA Benefits that I may elect?**'. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

Ask the Plan Administrator if you need further information about which expenses are and are not likely to be reimbursable.

Article VIII
DEPENDENT CARE REIMBURSEMENT ACCOUNT

What are "DCAP Benefits"?
As described under '**What benefits may be elected under the Cafeteria Plan?**', a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP). As described under '**How do employees pay for Benefits on a pre-tax basis?**', if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See '**What tax savings are possible under the Cafeteria Plan?**' for an example dealing with pre-tax payment of Premium Insurance contributions.

After you satisfy the eligibility requirements described above, you may participate in the DCAP on the same day as the Employer's group medical plan by signing an individual Election Form/Salary Reduction Agreement as described under '**How do I become a Participant and when is my Entry Date?**'

What is my "DCAP Account"?
If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

What are the maximum DCAP Benefits that I may elect under the Cafeteria Plan?
You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in DCAP Benefits, you'll pay for the benefits with a $3,000 salary reduction). The amount of Dependent Care Expense reimbursement that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code § 129 when your election is made. The $5,000 maximum will apply to you if:

* you are married and file a joint federal income tax return;
* you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or
* you are single or the head of the household for federal income tax purposes. If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code § 129 is $2,500 for a calendar year. These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described under 'What are "Dependent Care Expenses" that may be reimbursed?' (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

How are my DCAP Benefits paid for under the Cafeteria Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for $2,600 per year for Dependent Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. Your DCAP Account would be credited with a total of $2,600 by the end of the Plan Year. If you are paid bi-weekly, then your DCAP Account would reflect that you have paid $100 ($2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected. The Employer makes no contribution to your DCAP Account.

What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?
The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

Using the example under 'How are my DCAP Benefits paid for under the Cafeteria Plan?', suppose that you incur $1,500 of Dependent Care Expenses by the end of March. At that time, your DCAP Account would only have been credited with $700 ($100 times seven pay periods), so only $700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements).

You may also be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. (See '**When must the Dependent Care Expenses be incurred for the DCAP?**')

What are "Dependent Care Expenses" that may be reimbursed?
"Dependent Care Expenses" means employment-related expenses incurred on behalf of a person who meets the requirements to be a "Qualifying Individual," as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

* Each person for whom you incur the expenses must be a Qualifying Individual, that is, he or she must be:

  - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
  - your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
  - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

  Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.

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

For more information about what items are—and are not—deductible Dependent Care Expenses, consult IRS Publication 503 ("Child and Dependent Care Expenses") under the heading "Tests to Claim the Credit." But use the Publication with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code §21 ("the Dependent Care Tax Credit," discussed further below), not what is reimbursable under a DCAP. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit (under Code §21) and what expenses are reimbursable under a DCAP (under Code §129). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. (For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought. (See F1B'When must the Dependent Care Expenses be incurred?').)

Ask the Plan Administrator if you need further information about which expenses are, and are not, likely to be reimbursable. You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

* your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);
* the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
* either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further under **'What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?'.**

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is $5,000.

When must the Dependent Care Expenses be incurred?
For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as the Plan Year for the Cafeteria Plan, a 12-month period beginning on July 1st and ending on June 30th .

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin immediately following the last day of the plan year and will end 2.5 months later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Cafeteria Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described under '**What must I do to be reimbursed for my Dependent Care Expenses?**').

Can I Continue DCAP Coverage After Terminating Employment?
When you cease to be a Participant under the DCAP Benefit, your salary reductions and election to participate will terminate also. However, the Participant will be able to receive reimbursements for Dependent Care Expenses incurred during the Period of Coverage following termination through the end of the Plan Year.

What must I do to be reimbursed for my Dependent Care Expenses?
When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see '**What happens if my claim for benefits is denied?**'). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. If you have ceased to be eligible as a Participant, you will have until 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible; you can also be reimbursed for expenses incurred following your termination of participation—that is through the balance of the current Plan Year and your claim is submitted by the 90-day deadline. You will be notified in writing if any claim for benefits is denied. (See '**What happens if my claim for benefits is denied?**'.)

The DCAP Benefit has a grace period which allows for an additional period of time of 2.5 months following the end of each Plan Year to incur expenses before the "use it or lose it" forfeiture rule applies. Thus, expenses incurred within 2.5 months after the close of the Plan Year can be reimbursed with funds carried over from the prior Plan Year.

The following additional rules will apply to Dependent Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

* Dependent Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your DCAP Account at the end of the current Plan Year and that you have also elected $2,400 of DCAP coverage for the new Plan Year. If you submit a $500 Dependent Care Expense that was incurred on January 15, of the new Plan Year, $200 of your claim will be paid out of the unused amounts remaining in your DCAP Account from the current Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the new Plan Year.
* Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 grace period expense, you discover $200 of 2019 Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2019 expenses. The Plan will not reprocess the $500 grace period expense so as to pay it entirely from your 2020 Dependent Care amounts. For this reason, if you also have Dependent Care coverage for the current year, you may want to wait to submit Dependent Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
* Expenses incurred during a grace period must be submitted by the 90 day(s) following the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, 90 days is also the deadline for submitting any claims for reimbursement of Dependent Care Expenses incurred during the preceding Plan Year.)

To have your claims processed as soon as possible, please read '**What happens if my claim for benefits is denied?**'. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined under '**When must the Dependent Care Expenses be incurred?**') and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Dependent Care Account, some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, Dependent Care Expenses incurred during a Grace Period may need to be submitted manually in order to be reimbursed from unused amounts in your Dependent Care Account from the preceding Plan Year if the card is unavailable for such reimbursement. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented.

Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?
Yes. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account-this is called the "use-it-or-lose-it" rule under applicable tax laws.

This benefit has a grace period which allows for an additional period of time of 2.5 months following the end of each Plan Year to incur expenses before the "use it or lose it" forfeiture rule applies. Thus, expenses incurred within 2.5 months after the close of the Plan Year can be reimbursed with funds carried over from the prior Plan Year. However, any unused amounts from the prior Plan Year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts

that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described under '**What are the time limits that affect forfeiture of my DCAP Benefits?**'.

What are the time limits that affect forfeiture of my DCAP Benefits?
You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year by the 90th day following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 90 days after the date you ceased to be eligible-see '**What must I do to be reimbursed for my Dependent Care Expenses?**'). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any DCAP Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Will I be taxed on the DCAP Benefits I receive?
Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth under '**What are the maximum and minimum DCAP Benefits that I may elect under the Cafeteria Plan?**'. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are, and are not likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice.

If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?
You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see '**What is the Dependent Care Tax Credit?**'). For example, if you elect $3,000 in coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Dependents.

What is the Dependent Care Tax Credit?
The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Dependent or $6,000 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Dependent or $2,100 for two or more Dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Dependent or $1,200 for two or more Dependents). The

maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross incomes exceeds $15,000.

Example: Assume that you have one Dependent for whom you have incurred Dependent Care Expenses of $3,600, and that your adjusted gross income is $20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more Dependents, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses").

Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?
For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Dependents, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you.

Ask the Plan Administrator if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that the Plan Administrator is not providing legal advice. Your Employer may also be able to provide you with a worksheet or tax calculator to help you make the comparison, ask the Human Resources Manager if you would like to use one or both of these.

Article IX
CLAIMS AND APPEALS PROCEDURES

Claims Procedure - In General
This section applies for any claim for benefits under a Welfare Benefit Plan that is covered by ERISA unless the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503, and with the Department of Labor Regulation sections 2560.503-1 and 2590.715-2719, including the disability benefit claims procedure. If the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Welfare Benefit Plan will apply. In general, this means that if the claims procedure of the Welfare Benefit Plan has timeframes and procedures that are at least as favorable to the Claimant or more favorable than the deadlines provided below, the claims procedure of the Welfare Benefit Plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

Any person entitled to benefits from the Welfare Benefit Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable Benefit Provider in accordance with the Benefit Provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Benefit Provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Welfare Benefit Plan's Plan Administrator. Any claim must include all information and evidence that the Benefit Provider or Plan Administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, the Claimant will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the Claimant's inquiry is an attempt to file a claim.

If the Claimant wishes to bring a claim for benefits under the Plan, they may designate an authorized representative to act on their behalf so long as they provide written notice of such designation to the applicable Benefit Provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Claimant's medical condition may act as their authorized representative with or without prior notice.

Timing of Notice of Claim
The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time, but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims
Group health Plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

Urgent Care. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the Plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The Welfare Benefit Plan will notify a Claimant of any reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the Claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days within which to provide the specified information.

Other Claims

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim
If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

Article X
FUNDING

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

How long will the Cafeteria Plan remain in effect?
Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

Article XI
GENERAL INFORMATION

What other general information should I know?
This question contains certain general information that you may need to know about the Plan. **Note:** This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan.

General Plan Information

* Name: County of Currituck Flexible Benefit Plan
* Plan Number: 527
* Effective Date: July 1, 2020
* Original Effective Date: July 1, 2010
* Plan Year: July 1st to June 30th. Your Plan's records are maintained on this 12-month period of time.
* Type of Plan: Fringe Benefit and Welfare plan providing Benefits
* Your plan shall be governed by the Laws of the State of North Carolina

Employer/Plan Sponsor Information

* Name and Address: County of Currituck
  153 Courthouse Road
  Currituck, NC 27929
  (252) 232-3228
* Federal Employer Tax Identification Number (EIN): 56-6000292

Plan Administrator Information
Name, address, and business telephone number:

County of Currituck
153 Courthouse Road
Currituck, NC 27929
(252) 232-3228

The Plan Administrator appoints the Plan Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The Plan Administrator will answer any questions that you may have about our Plan. You may contact the Plan Administrator at the above address for any further information about the Plan.

Funding and Type of Plan Administration

This is a contract administration plan. A third-party administrator processes claims for the Plan. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.
All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy.

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

Named Fiduciary

The named fiduciary for the Health FSA Component is: Employer

Agent for Service of Legal Process
The name and address of the Plan's agent for service of legal process is:

County of Currituck
153 Courthouse Road
Currituck, NC 27929
(252) 232-3228

USERRA
The Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. §§ 4301-4335 (USERRA), was signed into law on October 13, 1994. USERRA prohibits discrimination in employment based on an individual's prior service in the uniformed services; current service in the uniformed services; or intent to join the uniformed services. An employer is also prohibited from discriminating against a person because of such person's attempt to enforce his or her rights under the Act. In addition, an employer may not retaliate against an individual for filing a USERRA claim, testifying, or otherwise providing assistance in any proceeding under the Act. USERRA also provides reemployment rights with the pre-service employer following qualifying service in the uniformed services. In general, the protected person is entitled to be reemployed with the status, seniority, and rate of pay as if he or she had been continuously employed during the period of service. USERRA applies to private employers, the Federal Government, and State and local governments. It also applies to United States employers operating overseas and foreign employers operating within the United States.

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

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)
Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
This new law amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Medical Insurance Plan Documents and Information
This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan.

Model COBRA Continuation Coverage General Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

Model General Notice Of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA **

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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 doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage *[choose and enter appropriate information: must pay or aren't required to pay]* for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your hours of employment are reduced, or
* Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

* Your spouse dies;
* Your spouse's hours of employment are reduced;
* Your spouse's employment ends for any reason other than his or her gross misconduct;
* Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
* You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

* The parent-employee dies;
* The parent-employee's hours of employment are reduced;

* The parent-employee's employment ends for any reason other than his or her gross misconduct;
* The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
* The parents become divorced or legally separated; or
* The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

* The end of employment or reduction of hours of employment;
* Death of the employee;
* *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
* The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to: *[Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for*

giving notice.]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

* The month after your employment ends; or
* The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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For more information visit https://www.medicare.gov/medicare-and-you.

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 the Employee Retirement Income Security Act (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

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.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]