

**CLOQUET PUBLIC SCHOOLS ISD #94
FLEXIBLE BENEFIT PLAN**

**SUMMARY PLAN DESCRIPTION
Restated: 10/01/2011**

Cloquet Public Schools ISD #94 Flexible Benefit Plan
(With Premium Payment, Health FSA, HSA, and DCAP Components)

Summary Plan Description

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Cloquet Public Schools ISD #94 Flexible Benefit Plan (With Premium Payment, Health FSA, HSA, and DCAP Components)

Summary Plan Description

INTRODUCTION

Cloquet Public Schools ISD #94 (the “Employer”) sponsors the Cloquet Public Schools ISD #94 Flexible Benefit Plan (With Premium Payment, Health FSA, HSA and DCAP Components) (the “Flexible Benefit 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. (Such plans are also known as “cafeteria plans.”) Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary describes the basic features of the Flexible Benefit Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Flexible Benefit Plan. If there is a conflict between the Flexible Benefit Plan documents and this Summary, then the Flexible Benefit Plan documents will control.

Q-1. 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 the Human Resource Manager 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).

Q-2. What benefits may be elected under the Flexible Benefit Plan?

The Flexible Benefit Plan includes the following four benefit plans:

- *Premium Payment Component (currently including Medical Insurance Benefits & Individually Paid Insurance Premiums)*—permits an Employee to pay for his or her share of contributions for the Group Medical Insurance Plan with pre-tax dollars. “Group Medical Insurance Plan” means the major medical plan that your Employer maintains for Employees, their Spouses, Dependents and “adult children”, providing major medical type benefits through a group insurance policy. Benefits provided under the Group Medical Insurance Plan are called “Medical Insurance Benefits.” Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called “Premium Payment Benefits”; “Medical Insurance Benefits” also include qualified insurance policies that employee acquires on their own and are not sponsored by the Employer. Premiums that qualify are: health, dental, vision, hospital indemnity, cancer, intensive care, Medicare Supplemental policies, COBRA premiums and Medicare Part B. Nursing home insurance (Long Term Care), policies that have cash value (life insurance), policies that have a return of premium provision and Medicare Part D do not qualify for pre-tax treatment under the Section 125 Plan.

- *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 in Q-22) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called “Health FSA Benefits.” As described in Q-22, the Health FSA election may be for:
 - General-Purpose Health FSA Coverage;
 - Limited (Vision/Dental/Preventive Care) Health FSA Coverage;
 - Employee-Only Health FSA Coverage; or
 - Employee-Plus-Children Health FSA Coverage.
- *Health Savings Account (HSA)*—permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee’s HSA trustee/custodian. Benefits provided under the HSA, which consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis (see Q-28), are called “HSA Benefits”; and
- *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 in Q-43) 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.

Q-3. Who can participate in the Flexible Benefit Plan?

Employees who are regularly scheduled to work 15 or more hours per week are eligible to participate in the Flexible Benefit Plan (including the Health FSA Benefits, the DCAP Benefits, and the Individually Paid Insurance Premium Benefits) following 60 days of employment with the Employer, provided that the election procedures in Q-5 are followed. Eligibility and waiting periods for the Medical Insurance Benefit and the HSA Benefit are subject to additional eligibility requirements determined by policy or contract. Eligibility for HSA Benefits also requires that a participant be an “HSA-Eligible Individual.” See Q-28 for additional information.

An “Employee” is an individual who the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll. A definition of an Employees does not, however, include the following: (a) any common-law employee who is a leased employee or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee even if such an individual is later re-classified as a common-law employee; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency; or (c) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Q-4 What tax savings are possible under the Flexible Benefit Plan?

You may save federal, state income tax and FICA (Social Security) taxes by participating in the Flexible Benefit Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Medical Insurance Benefits under the Flexible Benefit Plan. Suppose that you are married and have one child and that your share of the required contributions for Medical Insurance Benefits for family coverage is an annual total of \$6,400. Suppose also that your gross pay is \$75,000 and your Spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce \$6,400 to pay for the Medical Insurance contributions, then your annual take-home pay would be \$56,979. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only \$55,529. This is because by participating in the Flexible Benefit Plan for Medical Insurance contributions, you will be considered for tax purposes to have received \$68,600 in gross pay, so you save \$1,450 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.

	Cafeteria Plan*	No Cafeteria Plan
I. Adjusted Gross Income	\$75,000	\$75,000
2. Salary Reductions for Premiums	(\$6,400)	\$0
3. W-2 Gross Wages	\$68,600	\$75,000
4. Standard Deduction	(\$10,700)	(\$10,700)
5. Exemptions	(\$10,200)	(\$10,200)
6. Taxable Income (line 3 minus lines 4 & 5)	\$47,700	\$54,100
7. W-2 Gross Wages	\$68,600	\$75,000
8. Federal Income Tax (line 6 @ tax schedule)	(\$6,373)	(\$7,333)
9. FICA Tax (7.65% of line 3)	(\$5,248)	(\$5,738)
10. After-Tax Premium Payments	\$0	(\$6,400)
11. Pay After Taxes and Premium Payments (line 7 minus lines 8, 9 & 10)	\$56,979	\$55,529

- * The standard deduction, exemptions, and federal income tax rates for 2007 are found in IRS Rev. Proc. 2006-53. 2006-48 I.R.B. 996. The FICA tax rate is found at <http://www.ssa.gov/pressoffice/factsheets/colafacts2007.htm> (as visited Mar. 9, 2007).

Q-5. When does participation begin and end in the Flexible Benefit Plan?

After you satisfy the eligibility requirements described in Q-3, you become a Participant by signing an individual Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. You must complete the Election Form/Salary Reduction Agreement and return it to the Human Resource Office within the time period specified in the enrollment materials. (If you have not received the enrollment materials and/or the Election Form/Salary Reduction Agreement, ask the Human Resources Manager for copies.) An eligible Employee who fails to complete, sign, and file an Election Form/Salary Reduction Agreement as required will not be able to elect any benefits under the Flexible Benefit Plan until the next Open Enrollment Period (unless a “Change in Election Event” occurs, as explained in Q-7).

Employees who actually participate in the Flexible Benefit Plan are called “Participants.” An Employee continues to participate in the Flexible Benefit Plan until (a) termination of the Flexible Benefit 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 Medical Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Flexible Benefit Plan for certain periods. See Q-12.

See Q-8 and Q-12 for information about how termination of participation affects your Benefits.

Q-6. 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 Flexible Benefit Plan by signing and returning an individual Election Form/Salary Reduction Agreement. (See Q-5) You will be notified of the timing and duration of the Open Enrollment Period, which for a Plan Year generally will be one month preceding the new Plan Year.

The Plan Year is the 12 months beginning on each September 1 and ending on August 31. The Plan year is being changed to commence September 1 and ending August 31 beginning with the 2012 Plan Year. Subsequently, the 2011-12 Plan Year will be a “short” Plan Year. The Plan Year is the same for the Flexible Benefit Plan, the Premium Payment Plan, the Health FSA, the DCAP and the HSA Plan.

Q-7. Can I change my elections under the Flexible Benefit Plan during the Plan Year?

With the exception of HSA Benefits (for which prospective election changes generally are allowable), you generally cannot change your election to participate in the Flexible Benefit 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. During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various “Change in Election Events” that are described in the attachment entitled “When Can I Change Elections Under the Flexible Benefit Plan?” (found at the end of this Summary).

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 Flexible Benefit 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 Flexible Benefit Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

Q-8. 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 Flexible Benefit Plan will cease and you will not be able to make any more contributions to the Flexible Benefit Plan for Group Medical Insurance Benefits, Health FSA Benefits, HSA Benefits, DCAP Benefits and Individually Paid Insurance Premium Benefits. The Group Medical Insurance Benefits will terminate as of the date specified in the Group Medical Insurance Plan. See Q-12 and the booklets for the Group 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 Q-24. For reimbursement of expenses from the DCAP Account after termination of employment, see Q-45. For information about obtaining distributions from your HSA at any time, including after termination of employment, contact the trustee/custodian of your HSA established and maintained outside of the Plan.

For purposes of pre-taxing COBRA coverage for Group Medical Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Flexible Benefit Plan for certain periods. See Q-12.

If you are rehired within the same Plan Year and are eligible for the Flexible Benefit Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

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 in Q-3 before again becoming eligible to participate in the Plan.

Q-9. Will I pay any administrative costs under the Flexible Benefit Plan?

No. The cost is paid in part by the use of forfeitures, if any (see Q-26 and Q-47). The rest of the cost of administering the Flexible Benefit Plan is paid entirely by the Employer. A separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian for your HSA established and maintained by you outside of the Plan.

Q-10. How long will the Flexible Benefit Plan remain in effect?

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

Q-11. What happens if my claim for benefits is denied?

Group Medical Insurance Benefits. The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). For more information about how to file a claim and for details regarding the medical insurance company's claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Group Medical Insurance Plan.

HSA Claims Not Involving Issues Relating to Salary Reductions. Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Claims Under the Flexible Benefit Plan, Health FSA, DCAP and Premium Payment Benefit. However, if a claim for reimbursement under the Health FSA, DCAP or Individually Paid Insurance Premium Components of the Flexible Benefit Plan is wholly or partially denied, or (b) you are denied a benefit under the Flexible Benefit Plan (such as the ability to pay for Medical Insurance, Health FSA, HSA, DCAP or Individually Paid Insurance Premium Benefits on a pre-tax basis) due to an issue germane to your coverage under the Flexible Benefit Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Flexible Benefit Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA § 502(a) (where applicable).

Q-12. What is “Continuation Coverage” and how does it work?

Continuation Coverage is a State law that allows the employee and his/her dependent to continue medical coverage if coverage is lost due to certain events such as; loss of employment, loss of plan eligibility, divorce, separation etc. If an Employer has over 50 employees they are subject to COBRA rules that will allow an employee to continue health coverage. The Plans that are subject to these rules are the Group Medical Insurance Plan, the Health FSA Plan. The Individually Paid Insurance Premium Benefit is not sponsored by the Employer, other than allowing the premium to be deducted pre-tax from a participant’s wages, and therefore is not an ERISA Plan that must comply with these rules. The Dependent Care Benefits is not subject to these rules either.

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.

Q-13. How will participating in the Flexible Benefit 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 Flexible Benefit Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

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 Medical Insurance Benefits, HSA 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 Medical 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 Medical Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Group Medical 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 Group Medical 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 DCAP Benefits) 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 by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see the attachment entitled "When Can I Change Elections Under the Flexible Benefit Plan During the Plan Year?" found at the end of this Summary).

Q-15. What are "Premium Payment Benefits"?

As described in Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Group Medical 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, state income taxes and FICA (Social Security) taxes. See Q-4.

The Premium Payment Benefits offered under your Plan are for Group Medical Insurance Benefits & dental insurance benefits— this is group major medical insurance and Individually Paid Insurance Premium benefits as described in Q-11 . Other Employer sponsored plans may be added in the future.

Q-16. How are my Premium Payment Benefits paid?

As described in Q-1 and in Q-15, if you select the Group Medical Insurance Plan described in Q-15, 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).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Q-17. What are “Health FSA Benefits”?

As described in Q-2, 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 in Q-1, 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 federal, state income taxes and FICA (Social Security)/ Medicare taxes. See Q-4 for an example dealing with pre-tax payment of Medical 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.

In the event that an expense is eligible for reimbursement under both the Limited Health FSA and the HSA, you may seek reimbursement from either the Limited Health FSA or the HSA, but not both. Your Employer sponsors an HRA, in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Health FSA must pay first).

Q-18. 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:

- (a) General-Purpose Health FSA Coverage;
- (b) Limited (Vision/Dental/Preventive Care) Health FSA Coverage; or
- (c) Employee-Only Health FSA Coverage; or
- (d) Employee-Plus-Children Health FSA Coverage.

Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. If you are married and elect the General-Purpose Health FSA Coverage Option, your spouse will also be ineligible to make HSA contributions. In addition, because the Health FSA includes a grace period, if you have an election for Health FSA Benefits (other than the Limited Vision – Dental - Preventive Care) the Health FSA Coverage Option that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits or otherwise make contributions to an HSA for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is \$0 as of the last day of that Plan Year. Unless you have elected Employee-Only or Employee-Plus-Children Health FSA Coverage, your spouse (if you are married) will also be unable to make HSA contributions during this period, unless the balance in your Health FSA Account is \$0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

Q-19. What are the maximum Health FSA Benefits that I may elect?

You may choose any amount of Medical Care Expense reimbursement that you desire under the Health FSA, subject to the maximum reimbursement amount of \$5,000 per Plan Year or the IRS statutory limit in effect. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

Q-20. How are my Health FSA Benefits paid for under the Flexible Benefit 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 Flexible Benefit 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.

Q-21. 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 in Q-20) 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.

You may also be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a 2 ½ Month “grace period” following the end of the Plan Year. (See Q-23.)

Q-22. 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;
- Limited (Vision/Dental/Preventive Care) Health FSA Coverage;
- Employee-Only Health FSA Coverage; or
- Employee-Plus-Children Health FSA Coverage.

Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In addition, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is \$0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

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

(a) *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). Under the tax laws, “Medical Care Expenses” include expenses for medicines as well as expenses for prescription drugs.

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;

- costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- 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;
- transportation expenses of any sort, including transportation expenses to receive medical care;
- marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- over-the-counter medications not 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.

For more information about what items are—and are not—Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible.

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 you need an answer upon which you can rely, you may wish to consult a tax advisor.

(b) *Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option.* According to rules set forth in Code § 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical expenses as defined for a General-Purpose Health FSA in subsection (a) above. You may, however, be eligible to make/receive tax-favored contributions to a HSA and participate in a Limited Health FSA if the Health FSA reimbursement is limited to the following unreimbursed Code § 213(d) expenses:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums); or
- Services or treatments for "preventive care". Preventive care is defined in accordance with applicable rules and regulations under Code § 223(c)(2)(C). (This may include any prescription drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the reoccurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

(c) *Employee-Only Health FSA Option.* For purposes of the Employee-Only Health FSA Option, “Medical Care Expenses” means the expenses described under the General-Purpose Health FSA Option (see subsection (a) above), provided that the expenses were incurred only by you (as the Participant) and not by your Spouse or your Dependents. If your Spouse maintains an HSA or wishes to establish an HSA, your participation in the General-Purpose Health FSA Coverage Option described in subsection (a) above will cause your Spouse to be ineligible for an HSA. By electing the Employee-Only Health FSA Option, you can essentially retain general-purpose health FSA coverage for yourself while leaving open the possibility that your Spouse may be able to contribute to his or her own HSA. No expense incurred by your Spouse, Dependents or “adult child” will be reimbursed under this Health FSA to the extent that such expenses were incurred after you made the election to restrict coverage. When you submit a claim for reimbursement, you must certify that the expenses submitted for reimbursement were incurred by you.

(d) *Employee-Plus-Children Health FSA Option.* For purposes of the Employee-Plus-Children Health FSA Option, “Medical Care Expenses” means the expenses described under the General-Purpose Health FSA Option (see subsection (a) above), provided that the expenses were incurred only by you (as the Participant) or your child who also qualifies as your Dependent (and not by your Spouse). If your Spouse maintains an HSA or wishes to establish an HSA, your participation in the General-Purpose Health FSA Coverage Option described in subsection (a) above will cause your Spouse to be ineligible for an HSA. By electing the Employee-Plus-Children Health FSA Option, you can essentially retain general-purpose health FSA coverage for yourself and your children while leaving open the possibility that your Spouse may be able to contribute to his or her own HSA. No expense incurred by your Spouse (or a Dependent who is not your child) will be reimbursed under this Health FSA to the extent that such expenses were incurred after you made the election to restrict coverage. When you submit a claim for reimbursement, you must certify that the expenses submitted for reimbursement were incurred by you or your child who qualifies as your Dependent.

For purposes of the Health FSA and its Coverage Options, “Spouse” means the person who is legally married to you and is treated as a spouse under the Code. “Dependent” means your tax dependent under the Code and includes the definition of an “adult child” under the Health Reform Act of 2010, except that an individual’s status as a Dependent is determined without regard to the gross income limitation for a “qualifying relative. See the Plan Administrator for more information about which individuals will qualify as your Dependents.

Note: Because of recent changes in the Code, some individuals’ Medical Care Expenses may no longer qualify for tax-free reimbursement under a Health FSA. Your child (and in some cases, your stepchild, grandchild, brother, sister, stepbrother, stepsister, niece, or nephew) may no longer be considered to be your Dependent if he or she has the same principal place of abode with another person for more than half the year. For example, if you provide more than half of your child’s support, but he or she lives with a grandparent all year, then your child could be the grandparents tax dependent instead of yours (if other conditions are met). If you have children (or stepchildren, grandchildren, etc.) who do not reside with you and who are affected by this change, their expenses will no longer be eligible for tax-free reimbursement under the Health FSA. Other changes may apply as well to individuals who were previously eligible for tax-free Health FSA coverage.

Q-23. 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 Flexible Benefit Plan—it is the period beginning on October 1 and ending on August 31 (2011-12 “short” plan year). Subsequent Plan Years will be September 1 – August 31, a full 12 month Plan Year.

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a “grace period” following the end of the Plan Year. Grace periods will begin on September 1 and will end two months and 15 days later. Accordingly, the first grace period will be September 1, 2012 through November 15, 2012 and will apply to unused Health FSA amounts remaining at the end of the 2011-12 Plan Year.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid or billed. 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 Flexible Benefit Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year (except for certain expenses incurred during a grace period, as discussed below), or after a separation from service (except for Continuation Coverage, as described in Q-12).

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

- a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates (November 15); or
- a qualified beneficiary who has COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates (November 15).

See Q-24 regarding certain rules that apply to claims for reimbursement for Medical Care Expenses that are incurred during a grace period.

Q-24. 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 available 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 medical insurance carrier (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.

If you have paid the contributions for the Health FSA coverage that you have elected, then 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 Q-11). 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 November 30 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. However, if you have ceased to be eligible as a Participant, you will only have until 60 days after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible (or during any applicable grace period). You will be notified in writing if any claim for benefits is denied. (See Q-11)

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

- Medical 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 Health FSA Account at the end of the 2011-12 Plan Year and that you have also elected \$2400 of Health FSA coverage for 2012-13. If you submit a \$500 Medical Care Expense that was incurred on October 15, 2012, \$200 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2011-12 Plan Year and the remaining \$300 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2012-13 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 2011-12 Medical 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 2011-12 expenses. The Plan will not reprocess the \$500 grace period expense so as to pay it entirely from your 2012-13 Health FSA amounts. For this reason, if you also have health FSA coverage for the current year, you may want to wait to submit Medical Care Expenses you incur during the grace period until you are sure you have no remaining un-reimbursed expenses from the prior Plan Year.
- Expenses incurred during a grace period must be submitted by November 30 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, November 30 is also the deadline for submitting any claims for reimbursement of Medical Care Expenses incurred during the preceding Plan Year.)

To have your claims processed as soon as possible, please read Q-11 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 in Q-23) 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. In addition, expenses incurred during a grace period may need to be submitted manually in order to be reimbursed from unused amounts in your Health FSA 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.

Q-25. 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 or during the grace period immediately following the Plan Year (if you are eligible for the grace period—see Q-23) are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount—this is called the “use-it-or-lose-it” rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year or its grace period (if applicable), even if amounts are still left in your Health FSA Account. The difference between what you elected and what Medical Care Expenses were reimbursed will be forfeited at the end of the time limits described in Q-26.

Q-26. 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 your Health FSA Account that are not applied to pay expenses submitted by November 30 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 may forfeit such amounts on an earlier date—see Q-24). 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, un-cashed 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.

Q-27. 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 in Q-19. 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.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical 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 you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-28. What are “HSA Benefits”?

As described in Q-2, an HSA permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee’s HSA trustee/custodian. For purposes of this Flexible Benefit Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Flexible Benefit Plan.

As described in Q-1, if you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions 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 Q-4 for an example dealing with pre-tax payment of Medical Insurance contributions.

To participate in the HSA Benefits, you must be an “HSA-Eligible Individual.” This means that you are eligible to contribute to an HSA under the requirements of Code § 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer. (“High Deductible Health Plan” means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2) as described in materials that will be provided separately to you by the Employer.) If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage—and you should be aware that coverage under a Spouse’s plan could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax Salary Reductions through the Employer's payroll system to the designated HSA trustee/custodian.

If you elect Health FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In addition, because the Health FSA includes a grace period, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits (or otherwise make contributions to an HSA) for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is \$0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

Q-29. What is my “HSA”?

The HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of “eligible medical expenses” as set forth in Code § 223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, choose an HSA provider to whom it will forward pre-tax Salary Reductions. The HSA trustee/custodian, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary-Reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

Q-30. What are the maximum HSA Benefits that I may elect under the Flexible Benefit Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect (for example, if the maximum \$5,650 annual benefit amount is elected for 2007, then the annual contribution amount is also \$5,650). The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. (Note: \$3,100 for single and \$6,250 for family are the statutory maximum amounts for 2012. An additional catch-up contribution \$1000 may be made if you are age 55 or older (you must certify your age to your Employer).

In addition, the maximum annual contribution shall be:

- (a) reduced by any matching (or other) Employer contribution made on your behalf; and
- (b) pro-rated for the number of months in which you are an HSA-Eligible Individual (as described in Q-28).

Note that if you are an HSA-Eligible Individual for only part of the year but you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA on September 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the

Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code § 223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 20% penalty (exceptions apply in the event of death or disability).

Q-31. How are my HSA Benefits paid for under the Flexible Benefit Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make 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 contribute up to \$1,000 per year for HSA Benefits and that you have chosen no other benefits under the Flexible Benefit Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of \$1,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid \$38.46 (\$1,000 divided by 26) each pay period in contributions for the HSA Benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

The Employer may or may not make contributions to your HSA. As described in Q-29. Other than payroll deducted contributions, your Employer has no authority or control over extra funds deposited in your HSA.

Q-32. Will I be taxed on the HSA Benefits that I receive?

You may save both federal and state income taxes and FICA (Social Security) taxes by participating in the Flexible Benefit Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other Benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Flexible Benefit Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-33. Who can contribute to an HSA under the Flexible Benefit Plan?

Only Employees who are HSA-Eligible Individuals can participate in the HSA Benefits. As described in Q-28, an HSA-Eligible Individual means an individual who meets the eligibility requirements of Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

Q-34. Can I change my HSA Contribution under the Flexible Benefit Plan?

As described in the attachment “When Can I Change Elections Under the Flexible Benefit Plan?” (found at the end of this Summary), you may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements. See Q-8.

Q-35. Where can I get more information on my HSA and its related tax consequences?

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

Q-36—37. [Reserved]

Q-38. What are “DCAP Benefits”?

As described in Q-2, 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 in Q-1, 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 federal and state income taxes and FICA (Social Security) and Medicare taxes. See Q-4 for an example dealing with pre-tax payment of Medical Insurance contributions.

Q-39. 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 and 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.

Q-40. What are the maximum DCAP Benefits that I may elect under the Flexible Benefit 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 in Q-43 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Q-41 How are my DCAP Benefits paid for under the Flexible Benefit 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 \$2,400 per year for Dependent Care Expenses and that you have chosen no other benefits under the Flexible Benefit Plan. Your DCAP Account would be credited with a total of \$2,400 by the end of the Plan Year. If you are paid semi-monthly, then your DCAP Account would reflect that you have paid \$100 (\$2,400 divided by 24) each pay period in contributions for the DCAP Benefits that you have elected.

The Employer makes no contribution to your DCAP Account.

Q-42. 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 in Q-41, suppose that you incur \$1,500 of Dependent Care Expenses by the end of December 2011, at that time your DCAP Account would only have been credited with \$600 (\$100 times six pay periods), so only \$600 would be available for reimbursement at the end of December (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining \$900 in Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account (you could request a \$100 reimbursement after each of the next nine pay periods).

Q-43. 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 non-custodial 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.

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 you need an answer upon which you can rely, you may wish to consult a tax advisor.

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 Flexible Benefit 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 in Q-40.

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.

Q-44. 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 and during the 2 1/2 Month “grace period” as provided for the Medical FSA. The Plan Year for the DCAP is the same as for the Flexible Benefit Plan — it is the 2011-12 period beginning on October 1 and ending on August 31, a “short” Plan Year. Subsequent Plan Years will be September 1 – August 31, a full 12 month Plan Year.

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 Flexible Benefit 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 in Q-45).

Q-45. 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 available 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 Q-11). 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 reimbursement cycles, 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 November 30 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. However, if you have ceased to be eligible as a Participant, you will only have until 60 days after the date you ceased to be eligible 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 in the month following your termination of participation if such month is in 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 Q-11)

To have your claims processed as soon as possible, please read Q-11. 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 in Q-44) and that it is not being paid for or reimbursed from any other source.

Q-46. 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. 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 and subsequent “grace period, 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 in Q-47.

Q-47. 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 November 30, the run out period, 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 60 days after the date you ceased to be eligible—see Q-45). 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, un-cashed 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.

Q-48. 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 in Q-40. 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 you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-49. 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 Q-50). 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 Qualifying Individuals.

Q-50. 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 Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. 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 Qualifying Individual, or \$2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one Qualifying Individual, or \$1,200 for two or more Qualifying Individuals). 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 income exceeds \$15,000.

Example: Assume that you have one Qualifying Individual for whom you have incurred Dependent Care Expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one Qualifying Individual 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 \times 32\% = \960 . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $\$3,600 \times 32\% = \$1,152$, 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”). You may also wish to consult a tax advisor, as discussed below.

Q-51. 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. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better) 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 Qualifying Individuals, 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. But if you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-52. What are my ERISA Rights?

The Flexible Benefit Plan and the HSA Component are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Medical Insurance Plan are governed by ERISA. Note: 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. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

Your Rights. As a participant in the Flexible Benefit Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your Group Medical Insurance Plan coverage (and, in some cases your Health FSA coverage) for yourself if there is a loss of coverage under the plan as a result of a qualifying event you or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note: This does not apply to the Health FSA which is an "excepted benefit" under HIPAA.)

HIPAA Privacy Rights. Under another provision of HIPAA group health plans (including the Health FSA) are required to take steps to ensure that certain “protected health information” (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other participants.

Non-Discrimination. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Right to Review. If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforcing Your Rights. Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the plan’s claims procedures and, if applicable, filed a timely appeal of any denial of your claim).

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Q-53. What other general information should I know?

This Q-53 contains certain general information that you may need to know about the Plan.

Note: This Summary Plan Description does not describe the Group Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

- Name: Cloquet Public Schools ISD #94. Flexible Benefit Plan.
- Plan Number: 510
- Effective Date: January 1, 2006 and restated October 1, 2011.
- Plan Year: October 1 to August 31 (a “short Plan Year”). Subsequent Plan Years will be September 1 – August 31. Your Plan’s records are maintained on this 12-month period of time.
- Type of Plan: Welfare plan providing Group Medical Insurance Benefits, Health FSA Benefits, and DCAP Benefits.

Employer/Plan Sponsor Information

- Name and Address:
Cloquet Public Schools ISD #94.
302 14th Street
Cloquet, MN 55720
- Federal employee tax identification number (EIN): 41-6000450

Plan Administrator Information

- Name, address, and business telephone number:
Cloquet Public Schools ISD #94.
302 14th Street
Cloquet, MN 55720
Attention: Human Resources Manager
Telephone Number: (218) 879-6721
- The Plan Administrator appoints the Human Resources Manager to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Benefits Committee acts on behalf of the Plan Administrator with respect to appeals. The Human Resources Manager will answer any questions that you may have about our Plan. You may contact the Human Resources Manager at the above address for any further information about the Plan.

Funding Medium and Type of Plan Administration.

The Health FSA Component is a group health plan. The health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Cloquet Public Schools ISD #94.
302 14th Street
Cloquet, MN 55720
Telephone Number: (218) 879-6721

Agent for Service of Legal Process

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

Cloquet Public Schools ISD #94.
302 14th Street
Cloquet, MN 55720
Attention: Benefits Committee

Qualified Medical Child Support Order

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

Newborns' and Mothers' Health Protection Act of 1996

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

Medical Insurance Plan and HSA 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. Neither does this Summary Plan Description describe many aspects of the HSA Component (e.g., with respect to claims and reimbursement under the HSA). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

Attachment 1

When Can I Change Elections Under the Flexible Benefit Plan During the Plan Year?

Participants can change their elections under the Flexible Benefit 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 in Q-14); 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 that the Change in Election Events do not apply for all Benefits — applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative—see Q-7. Note also that no changes can be made with respect to Group Medical Insurance Benefits if they are not permitted under the Group 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 Group 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 Group Medical Insurance Benefits, Health FSA, and DCAP Benefits*). You may change an election under the Flexible Benefit Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. Change in Status. (*Applies to Group Medical Insurance Benefits, to Health FSA Benefits as Limited Below, and to 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 Flexible Benefit 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, ceasing to be a student, 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 Group Medical Insurance Benefits, Health FSA Benefits as Limited Below, 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 in Q-43) for the dependent care tax exclusion).

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute \$100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of \$700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of \$700 for the year. (See also Q-20 and Q-21.)

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 (here, the Group 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 Flexible Benefit Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See Q-12.

- *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 Flexible Benefit 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 Group Medical Insurance Benefits, but Not to Health FSA or DCAP 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, a copy of which was previously furnished to you. Contact the Human Resources Manager 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 Flexible Benefit Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. (*Applies to Group Medical Insurance Benefits and Health FSA Benefits, but Not to DCAP 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 Group 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 Group Medical Insurance Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP 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 may be canceled completely but not reduced. 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, Group Medical Insurance Benefits and/or Health FSA Benefits, as applicable).

7. Change in Cost. (*Applies to Group Medical Insurance Benefits, and to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.*) If the cost charged to you for your Group 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. (For these purposes, the Health FSA is not similar coverage with respect to the Group Medical Insurance Benefits and 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.) If the cost of Group Medical Insurance or DCAP Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option, you may change your election on a prospective basis to elect the benefit package option that has decreased in cost; or (c) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

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 or decreases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases or decreases 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 Group Medical Insurance Benefits and DCAP Benefits, but Not to Health FSA Benefits.*) You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Group Medical Insurance Benefits or 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 Group Medical Insurance Benefits or 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 Flexible Benefit Plan Option.* If the Flexible Benefit 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 change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *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 Flexible Benefit 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 Flexible Benefit 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.

9. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).